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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

5897  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Items 13 & 14, Film 6288 5/29/61 mh  
05884

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park		d. STREET ADDRESS 13 Yuma Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Frank Allen				4. DATE OF DEATH Month Day Year May 23 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 20, 1911	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 543X DUE TO CASTROINTESTINAL HEMORRHAGE (b) HEMORRHAGIC GASTRITIS (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEVERE FATTY INFILTRATION LIVER							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/23/61 James I. Boyd James I. Boyd Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 26, 1961		22c. NAME OF CEMETERY OR CREMATORY Allen Cemetery		22d. LOCATION (City, town, or country) (State) Tarheel, North Carolina	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Maryland.				24a. REC'D BY REGISTRAR MAY 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5898

05885

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN lb <b>2</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eugene Leland Memorial</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>1601 Riding Stable Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Susanna</b> Middle <b>REBECCA</b> Last <b>Appel</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1961</b>		9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>	
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>NOT 2-18-83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. PLACE (County, State, or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph Tilghman</b>				14. MOTHER'S MAIDEN NAME <b>Rachel R. Boring</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>C. Hart Leland Memorial</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO <b>Coronary Artery Disease</b> (c) <b>Myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b> <b>Myocardial Infarction</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Myocardial Infarction</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Laurel, Prince George's Co., Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 29, 1959</b> to <b>May 29, 1961</b> that (I) <b>no</b> saw the deceased alive on <b>May 29, 1961</b> and that death occurred <b>May 29, 1961</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Rebecca Appel</b> M.D.				22b. DATE SIGNED <b>May 29, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Rebecca Appel</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 1-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Burgess Funeral Home</b>		ADDRESS <b>3631 Falls Road</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO CRITICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5893											
65886											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First Middle Last HATTIE ELIZABETH ATCHINSON						4. DATE OF DEATH Month Day Year May 31 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1897		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland, Charles Co.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sidney Pickeral						14. MOTHER'S MAIDEN NAME Emma ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Blanche Willett, Accokeek, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CA OF LIVER 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CA. OF CERVIX, PRIMARY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 MOS. 1 1/2 YRS											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from MAY 30, 19 60 to MAY 31, 19 61, that (I) (we) last saw the deceased alive on MAY 31, 19 61, and that death occurred at 7:05 PM from the causes and on the date stated above. 22a. SIGNATURE Paul Chen, M.D. 22b. DATE SIGNED MAY 31, 19 61 22c. PHYSICIAN'S NAME (Type) PAUL CHEN, M.D. 22d. ADDRESS ACCOKEEK, M.D. 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE Arthur S. Evans											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-3-61		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery				23d. LOCATION (City, town or county) (State) Accokeek, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Huntt Funeral Home, Waldorf, Maryland						25a. REC'D BY REGISTRAR DATE JUN 5 '61					

(M)

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George Jones

George

George Jones

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HATFIELD ELEANOR ATTACHED

George Jones

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HATFIELD ELEANOR ATTACHED

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CA OF CERVIX, PRIMARY

MAY 30 1961

MAY 31 1961

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ACACIA, MD

George Jones

George Jones

The Hunt Funeral Home, Baltimore, Maryland

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

bp

MEDICAL CERTIFICATION

<div> <div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>5900</div> <div>3</div> </div> <div> <div>FOR STATE HEALTH DEPT.</div> <div> <div>Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> <div>VS. A15ME 5M 7/59</div> <div>bp</div> </div>										<div> <div>3</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>5900</div> <div>3</div> </div> <div> <div>FOR STATE HEALTH DEPT.</div> <div> <div>Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> <div>VS. A15ME 5M 7/59</div> <div>bp</div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> c. LENGTH OF STAY IN 1b <u>6 year</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4706-68th Place</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> <u>38</u> d. STREET ADDRESS <u>4706-68th Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) <u>Willie Florence Barnett</u> First Middle Last <b>4. DATE OF DEATH</b> Month Day Year <u>May 28 1961</u>																			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept 21, 1896</u>		<b>9. AGE</b> (In years last birthday) <u>84</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mississippi</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>											
<b>13. FATHER'S NAME</b> <u>Frank Goode</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Scott</u>														
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <u>no</u>														
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)														
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)												
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> <b>M.D.</b> <b>EXAMINER'S NAME</b> (Type) <u>JAMES I. BOYD</u>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>5-29-61</u>														
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>June 1, 1961</u>		<b>22c. NAME OF CEMETERY OR</b> <u>George Washington</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>Hyattsville, Md.</u>													
<b>23. FUNERAL DIRECTOR</b> <u>F. Gasch's Sons</u> <b>ADDRESS</b> <u>Hyattsville, Md.</u>					<b>24a. REC'D BY REGISTRAR</b> <u>MAY 31 '61</u> <b>DATE</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>												

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5901

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1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W Hyattsville Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W Hyattsville Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2701 Kirkwood Place</b>				d. STREET ADDRESS <b>2701 Kirkwood Place</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Wilson</b> Last <b>Barr</b>				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 24, 1894</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>		11. BIRTHPLACE (State or foreign country) <b>West, Va</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Malhon H. Barr</b>				14. MOTHER'S MAIDEN NAME <b>Annabelle Ross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>232 260 123</b>		17. INFORMANT <b>Evelyn E Barr</b> Address <b>W Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Infiltrating Malignant Neoplasm of Cerebellum</b> DUE TO (c) <b>2 mos.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> 19 <b>61</b> , to <b>5/23</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/21</b> 19 <b>61</b> , and that death occurred at <b>12 Noon</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Earl W. Graff</b>				22b. DATE SIGNED <b>5/23/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>EARL W. GRAEFF, M.D.</b>				22d. ADDRESS <b>2716 Kirkwood Pl. W. Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Queens Point</b>		23d. LOCATION (City, town, or county) (State) <b>Keyser, West Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Busch's sons Hyattsville Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



(M)

CERTIFICATE OF DEATH

MADE IN THE DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
U.S. GOVERNMENT PRINTING OFFICE: 1964 O - 344-101

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Race: *White*  
4. Date of birth: *10/15/1920*  
5. Date of death: *11/10/1964*  
6. Place of death: *Home*  
7. Cause of death: *Heart Disease*  
8. Manner of death: *Natural*  
9. Signature of physician: *Dr. J. Smith*  
10. Signature of registrar: *John Doe*  
11. Date of registration: *11/15/1964*  
12. Place of registration: *City of New York*

201 General

10

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05890

**1. PLACE OF DEATH**

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clinton

c. LENGTH OF STAY in lb

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Southern Maryland Medical Center

USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rosaryville

d. STREET ADDRESS

Box 4113, Upper Marlboro, Md.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Joseph

Middle

Harold

Last

Batson

4. DATE OF DEATH

Month

May

Day

28,

Year

19 61

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

20 April 27, 1919

9. AGE (In years last birthday)

41 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

General

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Richard M. Batson

14. MOTHER'S MAIDEN NAME

Rosa Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

WWII

16. SOCIAL SECURITY NO.

218-09-0377

17. INFORMANT

Mrs Ellen Cook,

Route # 2, Box 1314 Upper Marlboro, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Hemorrhage and Shock

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Shot gun wound of the left chest and neck

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

Shot during an altercation

20c. TIME OF INJURY

Month, Day, Year

5:20

May 28 19 61

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

2Dc. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Yard of Home

2Df. (City or town)

Rosaryville

(County)

P. G.

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

5/29/61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-1-61

22c. NAME OF CEMETERY OR CREMATORY

Arlington National

22d. LOCATION (City, town, or country)

Arlington,

(State)

Va.

23. FUNERAL DIRECTOR

ADDRESS

Myrtle K. Rollins

4339 Hunt Pl., N.E.

Wash., D.C.

REC'D BY REGISTRAR

MAY 31 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Hanks

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO COMPLETION OF THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

<p align="center"><b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> <span style="float: right;">65891</span></p>											
<p>1. PLACE OF DEATH e. COUNTY <b>Prince George's</b> <b>MARYLAND</b></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b></p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b></p>						<p>c. LENGTH OF STAY IN IL <b>3 months</b></p>					
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5113 54th Avenue</b></p>						<p>d. STREET ADDRESS <b>5113 54th Avenue</b></p>					
<p>3. NAME OF DECEASED (Type or print) <b>Stanley Aloysius Beall</b></p>						<p>4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>19 61</b></p>					
<p>5. SEX <b>Male</b></p>		<p>6. COLOR OR RACE <b>White</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>October 23, 1905</b></p>		<p>9. AGE (In years last birthday) <b>55</b> yrs.</p>		<p>IF UNDER 1 YEAR Months <b>1</b> Days <b>39</b></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Goods</b></p>				<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>			
<p>12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b></p>				<p>13. FATHER'S NAME <b>George W. Beall</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Carrie V. Chaney</b></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b></p>				<p>16. SOCIAL SECURITY NO. <b>WW 11 578-05-1894</b></p>				<p>17. INFORMANT <b>Miss Virginia Beall, 6148 Shadyside Ave., Capital Heights, Md</b></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY Edema</b> DUE TO (b) <b>Hypertrophy and DILATATION, HEART</b> DUE TO (c) <b>MYOCARDIOSIS</b></p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FATTY DEGENERATION OF LIVER</b></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and in my opinion death resulted from: Natural causes <input type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <b>James I. Boyd</b></p>						<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>					
<p>EXAMINER'S NAME (Type) <b>James I. Boyd</b></p>						<p>DATE SIGNED <b>May 27, 1961</b></p>					
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>				<p>22b. DATE THEREOF <b>5-31-1961</b></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b></p>		<p>22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b></p>			
<p>23. FUNERAL DIRECTOR <b>W. W. Chambers Co Riverdale, Md</b></p>						<p>24a. REC'D BY REGISTRAR <b>MAY 31 '61</b></p>		<p>24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b></p>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5904

05892

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN lb <b>2 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hyattsville Convescent Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE -- b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>1550 41st. St., S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>Esther C Benesh</b>				<b>4. DATE OF DEATH</b> Last <b>May 30,</b> Month <b>19 61</b> Day <b>19 61</b>											
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan. 18, 1893</b>		<b>9. AGE</b> (In years last birthday) <b>68</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>19 61</b>		<b>IF UNDER 24 HRS.</b> Hours <b>19 61</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> --				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Denmark</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Theodore Benesh Jorgenson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Caroline</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Otto Benesh-#2d above-Son</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>181.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma of urinary bladder</b> DUE TO <b>181.0</b> (c) <b>181.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>181.0</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b> <b>1 1/2 yrs</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Suitland, Maryland</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from 5/25, 1961, to 5/30, 1961, that (I) (we) last saw the deceased alive on 5/29, 1961, and that death occurred at 6:25 A.M. from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>Harold F. McCann</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <b>5/30/61</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>HAROLD F. MCCANN</b>				<b>22d. ADDRESS</b> <b>3355-16th N.W. WASH. D.C.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation 5/31/61</b>				<b>23b. DATE THEREOF</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland, Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James T. Ryan, Inc.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>JUN 1 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur A. Howard</b>							

(M)

(I)

James Y. Ryan, Inc., 350 Fifth Ave., New York 17, N.Y.  
Chicago, Illinois

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5905 <span style="float: right;">05893</span>											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY in 1b <b>D. O. A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>				d. STREET ADDRESS <b>9136 Lanham Severn Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>XXXXXX Arthur Pendleton Bennett</b>			4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1961</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 8, 1902</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>George Washington Bennett</b>						14. MOTHER'S MAIDEN NAME <b>Mammie Harper</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW 11</b>				16. SOCIAL SECURITY NO. <b>242-09-2607</b>		17. INFORMANT <b>Mrs Mable C. Bennett, same as # 2</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>James I. Boyd</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>May 20, 1961</b> Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/24/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Maryland</b>						24a. REC'D BY REGISTRAR <b>MAY 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kramer</b>			

FOR SIGNATURE

(M)

(I)

6-30

1961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
MAY AND STATE OF NEW YORK	
DEPARTMENT OF HEALTH	
1. Name of Deceased: <u>John Doe</u>	
2. Sex: <u>Male</u>	
3. Age: <u>45</u>	
4. Date of Birth: <u>1916</u>	
5. Place of Birth: <u>New York City</u>	
6. Usual Residence: <u>123 Main St, New York City</u>	
7. Date of Death: <u>June 15, 1961</u>	
8. Time of Death: <u>10:00 AM</u>	
9. Place of Death: <u>Home</u>	
10. Cause of Death: <u>Heart Disease</u>	
11. Manner of Death: <u>Natural</u>	
12. Signature of Medical Examiner: <u>[Signature]</u>	
13. Signature of Coroner: <u>[Signature]</u>	
14. Signature of Registrar: <u>[Signature]</u>	
15. Date of Filing: <u>June 16, 1961</u>	
16. File Number: <u>100-1-100000</u>	
17. District: <u>1</u>	
18. City: <u>New York</u>	
19. State: <u>New York</u>	
20. Country: <u>USA</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05894											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS Rt. #1 Box 486					
3. NAME OF DECEASED (Type or print) First Middle Last Kenton Harper Beverage						4. DATE OF DEATH Month Day Year May 22 19 61					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-24-07		9. AGE (In years birthday) yrs. 54		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Pr. Geo's Co.				11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Beverage						14. MOTHER'S MAIDEN NAME Caroline Simmons					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Address Md. Alice R. Beverage Rt #1, Box 486 Clinton,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 180X DUE TO Hyper-Nephroma, Rt. Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 7, 19 61 to May 22, 19 61 that (I) (we) last saw the deceased alive on May 22, 19 61, and that death occurred at 1:40 AM from the causes and on the date stated above.											
22a. SIGNATURE John K. Roberts M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) 6300 Riverdale Road, Riverdale, Maryland						22d. ADDRESS 6300 - Riverdale Rd, Riverdale, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24-61		23c. NAME OF CEMETERY OR CREMATORY Beverage Cemetery		23d. LOCATION (City, town or county) West Union, West Virginia		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				1661- Good Hope Road SE Washington, DC				25a. REC'D BY REGISTRAR DATE MAY 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



(M)

George George

Claverly

Claverly

Claverly

Prince George's General Hospital

Box 100

London

London

Wife

1-24-02

Truck Driver

Virginia

Andrew Lawrence

Andrew Lawrence

1-24-02

1-24-02

Department

Department

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1-24-02

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05895

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>413 COMPTON AVE</b>		d. STREET ADDRESS <b>413 Compton Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>TAVENNER</b> Last <b>BIRDSONG</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 8 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN V. TAVENNER</b>	
14. MOTHER'S MAIDEN NAME <b>EMMA THOMAS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>THEODORE BIRDSONG</b> Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INSUFFICIENCY</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>MONTHS</b> <b>YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>—</b> , 1956, to <b>MAY 16</b> , 1961, that I last saw the deceased alive on <b>MAY 13</b> , 1961, and that death occurred at <b>1A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>402 MAIN ST LAUREL MD</b> DATE SIGNED <b>5/16/61</b>			
ACTUAL SIGNATURE <b>John R. Buell</b>		PHYSICIAN'S NAME (Type) <b>John R. Buell</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/18/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cemetery Arlington, Virginia</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>2901 14th St., N.W. Washington 9, D.C.</b>	
24a. REC'D BY REGISTRAR <b>MAY 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5908

05896

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>Hyattsville</b> d. NAME OF HOME OR INSTITUTION (If not in hospital, give street address) <b>Edmonston Ave.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>Edmonston Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARIETTA BONACCORSY</b>				4. DATE OF DEATH <b>May 19 1961</b>			
5. SEX <b>White</b>		6. COLOR OR RACE <b>Female</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 26, 1884</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Bonaccorsy</b>				14. MOTHER'S MAIDEN NAME <b>Angeline LaMantia Cala</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give number and date of service) <b>None</b>		17. INFORMANT <b>Nunzio Bonaccorsy Wash., D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic</b> DUE TO <b>Heart &amp; bad my disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1960</b> to <b>May 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>5-19-1961</b> , and that death occurred at <b>3P</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>George J. Hage</b>				22b. DATE SIGNED <b>5-19-61</b>		22c. PHYSICIAN'S NAME (Type) <b>George J. Hage M.D.</b>	
22d. ADDRESS <b>3717-38th Ave. Ridge City Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 23, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manoe, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>				25a. REC'D BY REGISTRAR <b>Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>May 23 '61</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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5208

DEPARTMENT OF STATE

Office of the Secretary

Division of Intelligence

Section of Intelligence

Office of the Secretary

Division of Intelligence

Section of Intelligence

Italy

U.S.A.

Intelligence Section

Office of the Secretary

Section of Intelligence

Office of the Secretary

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*Handwritten notes and signatures in the center of the page.*

Office of the Secretary

Section of Intelligence

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Office of the Secretary

Section of Intelligence

Office of the Secretary



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

<div style="display: flex; justify-content: space-between;"> <div> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b></p> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> <p><b>5909</b></p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>05897</b></p> </div> </div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>6 days</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>Rt. #2 Box 12</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Thomas A. Bowser</b> First Middle Last						<b>4. DATE OF DEATH</b> <b>May 27</b> Month Day Year									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4/23/74</b>		<b>9. AGE</b> (In years last birthday) <b>87</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Minn.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Thomas Bowser</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Ellen Ryan</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mrs. Mary Ahlquist</b>				<b>Address</b> <b>same</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <b>Anemia</b>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5-21</b> , 19 <b>61</b> , <b>to</b> <b>5-27</b> , 19 <b>61</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>5-26</b> , 19 <b>61</b> , <b>and that death occurred at</b> <b>11:45</b> M, <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>D.R. Purdie</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>D.R. PURDIE</b>						<b>22d. ADDRESS</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial May 31, 1961</b>				<b>23b. DATE THEREOF</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Assumption Cemetery</b>				<b>23d. LOCATION (City, town or county)</b> <b>Belle Plaine, Minnesota</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. W. ...</b>						<b>ADDRESS</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 2 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. ...</b>			

MEDICAL CERTIFICATION

5308

(M)

Prince George

Prince George

Prince George

Prince George

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Prince George

Prince George

(I)

Prince George

Prince George

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Prince George

Prince George

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Prince George

Prince George

5308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05898

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <i>3312 Buchanan Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Leland Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Elise S. Boyce</i>		4. DATE OF DEATH Month Day Year <i>May 28 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>7-26-1911</i>
9. AGE (In years last birthday) <i>49</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Alonzo Stowe</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic coma</i> DUE TO (b) <i>Hepatic failure</i> DUE TO (c) <i>Advanced Liver Cirrhosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>May 28 1961</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>May 21 1961</i> to <i>May 28 1961</i> , that (I) (we) last saw the deceased alive on <i>May 28 1961</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Theo. Zegarra, M.D.</i>		22b. DATE SIGNED <i>May 28 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Theo. Zegarra, M.D.</i>		22d. ADDRESS <i>3604 Oliver St Hyattsville, Ind</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial May 31 1961</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>Mount</i>		23d. LOCATION (City, town or county) (State) <i>North Carolina</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Busch Sons</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 31 '61</i>	
ADDRESS <i>Hyattsville Ind</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

(M)

(I)

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I have", "the", "and" are faintly visible.]*

## CERTIFICATE OF DEATH

Reg. Dist. No. 05899

5911

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES'</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>P.G.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN 1b <b>6 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1208 PARKER AVE-</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SO HYATTSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1208 PARKER AVE-</b>				d. STREET ADDRESS <b>1208 PARKER AVE-</b>			
3. NAME OF DECEASED (Type or print) <b>HERBERT JOHN BRANDES</b>				4. DATE OF DEATH <b>MAY 23 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 25, 1892</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED (GOVT)</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>HENRY BRANDES</b>				14. MOTHER'S MAIDEN NAME <b>AGNES STEINMETZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>578-12-7102</b>			
17. INFORMANT <b>H.G. BRANDES (SON)</b>				Address <b>Adelphi, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE VENTRICULAR FIBRILLATION</b> 420.1 DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>17 DAYS</b> DUE TO (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EMPHYSEMA, BILATERALLY, LUNGS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>MAY 7, 1961</b> , to <b>MAY 23, 1961</b> , that I last saw the deceased alive on <b>MAY 23, 1961</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Herbert M. Brandes</b>				ADDRESS (Street, city or town, state) <b>3400 UNIV. Blvd. E.</b>			
DATE SIGNED <b>5/23/61</b>							
PHYSICIAN'S NAME (Type) <b>HERBERT G. BRANDES-</b>				Adelphi, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 26, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO.,</b>				ADDRESS <b>Riverdale, Maryland</b>		24a. REC'D BY REGISTRAR <b>29 61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trans</b>				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5912											
05900											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN lb 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 71 7003 Dartmouth Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last MILTON WINFIELD BROCK						4. DATE OF DEATH Month Day Year May 26 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1890		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed				10b. KIND OF BUSINESS OR INDUSTRY Real Estate Broker				11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles W. Brock						14. MOTHER'S MAIDEN NAME Julia Kohler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. ADDRESS Hosp. records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Uremia Cardio vascular Renal Disease Conditions, if any, which gave rise to immediate cause (b) DUE TO General arterio sclerosis (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 mo undetermined	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
22c. PHYSICIAN'S NAME (Type) L W Malin M.D.		22d. ADDRESS Riverdale, Md		22e. SIGNATURE L W Malin		22f. DATE SIGNED 5-26-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/29/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town or county) (State) Rockville, Md			
24. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home, Mt Rainier, Inc. Md				24b. ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 31 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thayer			

10012

(10)

(1)

1/1/12

John F. Kennedy

Robert F. Kennedy

MAY 21 1961

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G287 5/22/61 mh

## CERTIFICATE OF DEATH

Reg. Dist. No. 05901

5913

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland, Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Washington 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home-4450-Whitehall Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES N. BROOKS				4. DATE OF DEATH Month Day Year May 17th 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1877	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Shop Worker Railroad		11. BIRTHPLACE (State or foreign country) LOWES, KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOE BROOKS				14. MOTHER'S MAIDEN NAME DORA WADE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT (Daughter) Mrs. Charles Campbell		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20, 1957, to May 16, 1961, that I last saw the deceased alive on May 16, 1961, and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank S. Pellegriani M.D.				ADDRESS (Street, city or town, state) 3609 Cedar Ave SE Wash DC		DATE SIGNED 5/17/61	
PHYSICIAN'S NAME (Type) FRANK S. PELLEGRINI				Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/1961		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Paducah, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Hysong Funeral Home 1300 N. St, N.W.				24a. REC'D BY REGISTRAR DATE MAY 18 '61		24b. REGISTRAR'S SIGNATURE	





## CERTIFICATE OF DEATH

Reg. Dist. No. 5914

1. PLACE OF DEATH COUNTY <b>6723 New Hampshire Ave Takoma Park Md. Montgomery Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery P. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park Md.</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6723 New Hampshire Ave Takoma Park Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>6723 New Hampshire Ave Takoma Park</b>	
3. NAME OF DECEASED (Type or print) <b>Florence C Brown</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		13. FATHER'S NAME <b>James T Brown</b>	
14. MOTHER'S MAIDEN NAME <b>Caroline Jones</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>MISS GRACE BROWN</b>		INFORMANT <b>SAME AS ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) <b>20 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-15</b> 19 <b>61</b> to <b>4-15</b> 19 <b>61</b> , that I last saw the deceased alive on <b>5-15</b> 19 <b>61</b> , and that death occurred on <b>4-15</b> 19 <b>61</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John P. Chum</b>		DATE SIGNED <b>6-11-61</b>	
PHYSICIAN'S NAME (Type) <b>W. K. Huntemann &amp; Son</b>		ADDRESS (Street, city or town, state) <b>5732 Ga. Ave N. W.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 18, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. K. Huntemann &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

(M)

8723 New Hampshire Ave. Takoma Park Md. 20912  
 Maryland Montgomery Co.

8723 New Hampshire Ave. Takoma Park Md. 20912  
 Takoma Park Md. 20912

James E. Brown  
 White Female  
 1875 June 4, 1875  
 Brown  
 May 15, 1921

James E. Brown  
 None Male  
 Maryland V. S. A.

James E. Brown  
 Caroline Jones

Miss Grace Brown  
 NO

*James E. Brown*  
*Caroline Jones*

*James E. Brown*  
*Caroline Jones*

8723 New Hampshire Ave. Takoma Park Md. 20912  
 Washington D. C. Rock Creek Cem.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5915

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05904

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westwood	
3. NAME OF DECEASED (Type or print) First Isaac Middle Brown Last Brown		4. DATE OF DEATH Month May Day 7 Year 19 61	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Aug 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pr. Geo's. Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Catherine Pinkney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John E. Brown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral thrombosis (a), stating the underlying cause last. (c) Arteriosclerotic C.V. disease		INTERVAL BETWEEN ONSET AND DEATH 7 days 10 days 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 15 1961, to May 7 1961 that (I) (we) last saw the deceased alive on May 7 1961, and that death occurred at 4:45 PM from the causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 5-7-61	
22c. PHYSICIAN'S NAME (Type) Dr. George Hageage, M.D.		22d. ADDRESS 3717 38th Ave., Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10/61	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary		23d. LOCATION (City, town or county) (State) Rosaryville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George L. Nelson		25a. REC'D BY REGISTRAR MAY 12 '61	
ADDRESS Agassco Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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UNKNOWN

John E. Brown  
Catharine Finney  
P. Geo. Maryland

George Washington  
George Washington

George Washington

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5916

05905

1. PLACE OF DEATH e. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY in lb <b>7 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sampson</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>23 July 1909</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Columbia, S.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Brown</b>				14. MOTHER'S MAIDEN NAME <b>Anna Patterson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220 01 3743</b>			
17. INFORMANT <b>Eliza Brown</b>				Address <b>1315 69th Ave., Huntsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction left</b> <b>442X</b> DUE TO (b) <b>Hypertension &amp; renal disease</b> Conditions, if any, which gave rise to immediate cause (c) <b>renal disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 28</b> 19 <b>61</b> to <b>May 5</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>May 5</b> 19 <b>61</b> , and that death occurred at <b>11:00 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George Hageage</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-6-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George Hageage M.D.</b>				22d. ADDRESS <b>3717 38th Avenue Cottage City, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>5-12-61</b>		<b>Capernaum Church</b>		<b>Columbia S.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rolden Funeral Home</b>				ADDRESS <b>339 Hunt Pl. N.E.</b>		25a. REC'D BY REGISTRAR <b>MAY 10 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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- FOR STATE HEALTH DEPT. (M)  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. (I)  
VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5917 05906											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chaverly				c. LENGTH OF STAY in 1b D. O. A.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Uospital				d. STREET ADDRESS Marlboro Pike				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Gertrude Last Bryan				4. DATE OF DEATH Month May Day 13 Year 1961							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1879 81		9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James Baker Curtin				14. MOTHER'S MAIDEN NAME Elizabeth Kidwell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT James Alfred Bryan, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER				DATE SIGNED 5/14/61			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER				DEPUTY MEDICAL EXAMINER			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial				22b. DATE THEREOF 5/17/61				22c. NAME OF CEMETERY OR CREMATORY Rosaryville Cath. Cem.			
23. FUNERAL DIRECTOR Ritchie Bros.				ADDRESS Upper Marlboro, Md.				24a. REC'D BY REGISTRAR MAY 22 '61			
								24b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAY 8 '61  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>18</b> days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>2212 Beaumont St. S.E.</b>	
3. NAME OF DECEASED (Type or print) <b>Carl</b> First Middle Last		4. DATE OF DEATH <b>May 2 19 61</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 Dec. 1896</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>579 03 3305</b>	
17. INFORMANT <b>Ardelle Bullis</b>		Address <b>Temple Hills, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of the Left Lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-14-1961</b> to <b>May 2 1961</b> , that (I) (we) lost saw the deceased alive on <b>May 2 1961</b> , and that death occurred at <b>1:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. A. Sayan</b>		22b. DATE SIGNED <b>5-2-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. A. Sayan, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-5-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Mattingly</b>		25a. REC'D BY REGISTRAR <b>MAY 8 '61</b>	
ADDRESS <b>131-11th St. S.E. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Orthur S. Kraus</b>	

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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
5919									
05908									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hills			d. STREET ADDRESS 6031 St. Barnabas Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Alton Burch		4. DATE OF DEATH May 4th 1961		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years last birthday) 64		9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Frank Burch		14. MOTHER'S MAIDEN NAME Lula Berry		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 5100 Wheeler Road S.E. Oxon Hill, Md.	
17. INFORMANT Raymond Burch									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				May 4th. 1961	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-61		22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Church		22d. LOCATION (City, town, or county) (State) Oxon Hill, Md.			
23. FUNERAL DIRECTOR Charles A. Twing				ADDRESS 2500 Nichols Ave		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
						10 '61			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5920											
Items 8 & 9 Film G287 5/19/61 iwk 05949											
1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 6 Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 155 6th St.				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jefferson Carter				4. DATE OF DEATH Month Day Year May 8 1961							
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1909		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY P. RR		11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Carter				14. MOTHER'S MAIDEN NAME Mary Gray							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number and date of service)		17. INFORMANT Pearl Carter 155 6th St., Bowie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post operative intestinal abscess peritonitis DUE TO (c) Intestinal Obstruction due to adhesions PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 1 day 6 days ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 2, 1961, to May 8, 1961, that (I) (we) last saw the deceased alive on May 1, 1961, and that death occurred at 1:35 P from the causes and on the date stated above.											
22a. SIGNATURE Edward E. Connell Jr				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 9, 1961			
22c. PHYSICIAN'S NAME (Type) Edward E. Connell Jr M.D.				22d. ADDRESS 820 Quincy St N.W. Wash D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/61		23c. NAME OF CEMETERY OR CREMATORY Fork AMEZion, Wilsontown, Md.				23d. LOCATION (City, town or county) (State) Wash D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert F. Snowden				ADDRESS Rockville Md		25a. REC'D BY REGISTRAR MAY 15 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kinn			

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THE STATE  
OF NEW YORK

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OFFICE OF THE  
COMMISSIONER OF THE LAND OFFICE

1900

TO THE COMMISSIONER OF THE LAND OFFICE  
IN SENATE CHAMBERS  
ALBANY  
JANUARY 1, 1900

YOUR REPORT OF THE  
LAND OFFICE FOR THE YEAR  
1899, HAS BEEN RECEIVED  
AND IS HEREBY  
APPROVED.

WILLIAM W. LESTER,  
GOVERNOR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5922

## CERTIFICATE OF DEATH

65911

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>14 Hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 27</u>		d. STREET ADDRESS <u>5008 Hollyspring Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Len</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 18, 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Duplin, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.A.</u>	
13. FATHER'S NAME <u>Solomon Chestnut</u>				14. MOTHER'S MAIDEN NAME <u>Cressie (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577 14 0664A</u>		17. INFORMANT <u>Effie Chestnut</u>		Address <u>Same as 2d</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>non swi</u> <u>581.0</u> DUE TO <u>SI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of the liver</u> DUE TO (c) <u>16 the liver</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>61</u> to <u>May 12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 12</u> , 19 <u>61</u> , and that death occurred at <u>8:45 A.M.</u> on the causes and on the date stated above.							
22a. SIGNATURE <u>Max M. Herzberg</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Max Herzberg M.D.</u>				22d. ADDRESS <u>7016 Greig St</u> <u>Seat Pleasant, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Ruffin</u>				25a. REC'D BY REGISTRAR <u>4339 N. W. P. H. E.</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Ruffin</u>	

3882



*There is a...*

*...the ...*

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5923

## CERTIFICATE OF DEATH

05912

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u> d. STREET ADDRESS <u>9014 Old Fort Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>George</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>May 7 1961</u> Month Day Year		<b>9. AGE</b> (In years, last birthday) <u>46</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Charles County, Md.</u>			
<b>13. FATHER'S NAME</b> <u>Thomas Chew</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Maggie Queen</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs Madeline Gladdin Same</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Bronchopneumonia and pulmonary edema</u> (c) <u>Chronic pyelonephritis with abscess formation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u> <u>10 Days</u> <u>10 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>April 27, 1961</u> to <u>May 7, 1961</u> that (I) (we) last saw the deceased alive on <u>May 7, 1961</u> and that death occurred at <u>7:20 pm</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Max M. Herzberg</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Max Herzberg, M.D.</u>		<b>22d. ADDRESS</b> <u>7016 Greig St., Seat Pleasant, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5-11-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>National Harmony Cemetery</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John T. Rhoads &amp; Co</u>		<b>ADDRESS</b> <u>3015-12th St</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAY 15 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. House</u>							

232



James M. Smith

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1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05913

1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) West Hyattsville				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2400 Woodberry				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Myer Middle Soloman Last Cohn				4. DATE OF DEATH Month May Day 20, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1884	
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher				10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Leo Cohn				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 088-16-7696		17. INFORMANT Mrs Bertha Cohn, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes of ten years known standing							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) May 20, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1961		22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		22d. LOCATION (City, town, or country) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR ADDRESS Goldberg Funeral Home 4217 9th Street N.W.				24a. REC'D BY REGISTRAR DATE MAY 22 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rear of Fire Dept. Bldg.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BERNIS EDWARD COLE</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1930</u>	
9. AGE (In years last birthday) <u>30</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willie Cole</u>				14. MOTHER'S MAIDEN NAME <u>Mary McCain</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>242-44-5810</u>		17. INFORMANT <u>R. T. Cole, #53 I St., N.W., Wash., D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypertensive heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty Infiltration of Liver</u>							
20a. EXTERNAL CAUSE OF INJURY PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 23, 1961</u>							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M.D.</u>		Address (Street, city, town, or county) <u>W 21 Bacon 155 21</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR <u>W 21 Bacon 155 21</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>May 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White	
DATE OF DEATH Jan 15, 1910		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		CITY New York	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DISEASES PREEXISTING Hypertension		DISEASES PRODUCED None	
SIGNATURE OF EXAMINER [Signature]		SIGNATURE OF ATTENDING PHYSICIAN [Signature]		SIGNATURE OF NEAREST RELATIVE [Signature]		SIGNATURE OF WITNESS [Signature]	
LOCALITY New York		COUNTY New York		STATE New York		DATE Jan 15, 1910	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

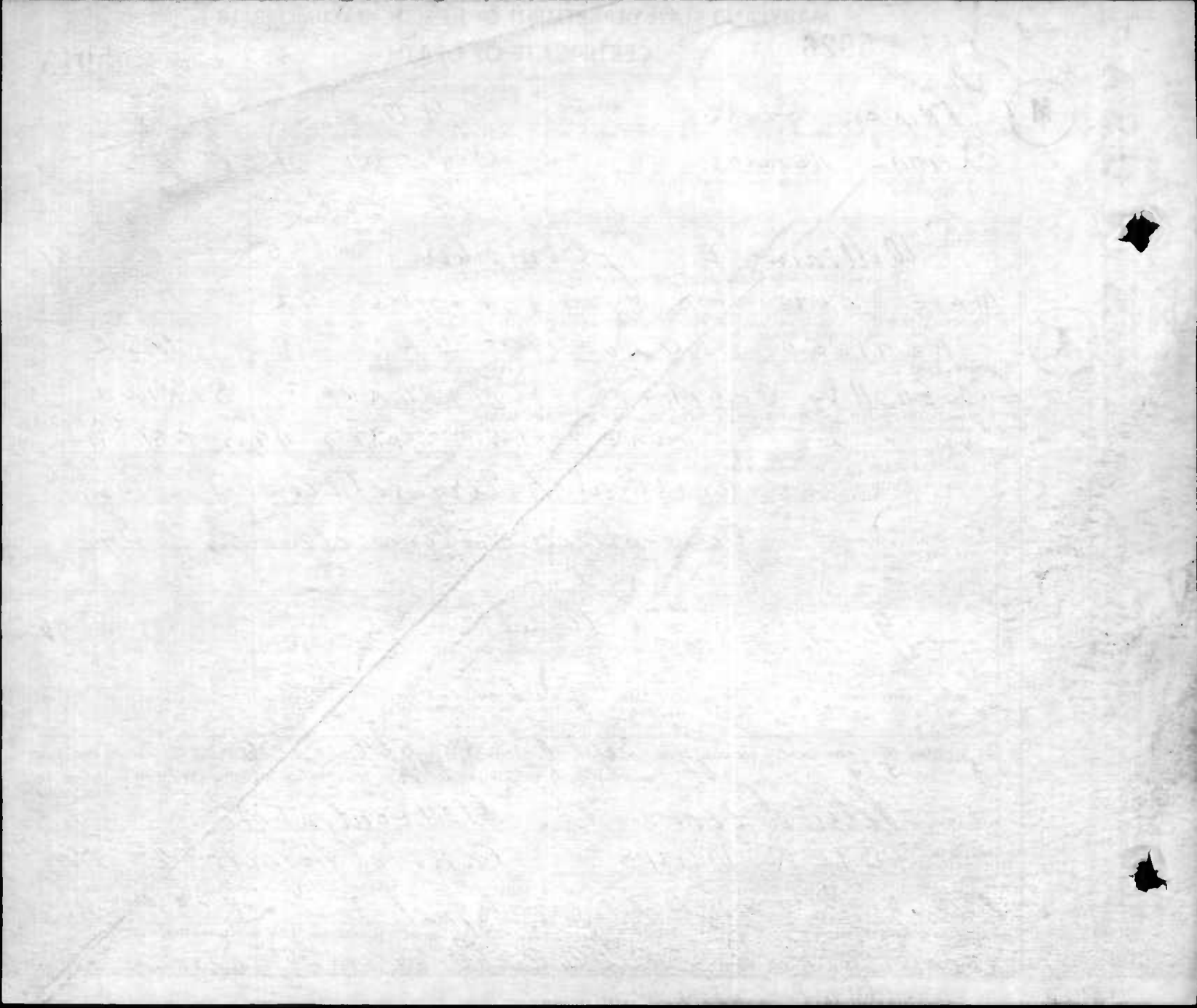
5926

## CERTIFICATE OF DEATH

Reg. Dist. No. 05915

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAPITAL HEIGHTS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAPITAL HEIGHTS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William E Compher</b>				4. DATE OF DEATH <b>5</b> Month <b>10</b> Day <b>1961</b> Year			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 23 1868</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDER</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H.W. Compher</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET SPRING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT Address <b>John Compher 4902 F St. CAPITAL HEIGHTS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> 334X DUE TO Conditions, if any, which gave rise to immediate course (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>3 yr. 3 yr.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 yr. 3 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrene of both feet</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>Sept 1</b> , 19 <b>58</b> , to <b>5/10</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/4</b> , 19 <b>61</b> , and that death occurred at <b>2:45</b> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Peter Duus</b>				ADDRESS (Street, city or town, state) <b>6124 Central Ave</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>PETER DUUS</b>				<b>Capitol Heights 27 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>5-13-61</b>		<b>Addison Chapel</b>		<b>Seat Pleasant Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Funeral Home</b>				ADDRESS <b>4812 9a Ave NW</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 15 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			







1  
FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MAY 19 1961											
<p>1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u> c. LENGTH OF STAY IN 1b <u>12 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3108 Lake Ave. Cheverly, Md</u></p>											
<p>2. USUAL RESIDENCE (Where deceased lived, if institution's Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> d. STREET ADDRESS <u>3108-Lake Ave. Cheverly, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>3. NAME OF DECEASED (Type or print) <u>JAMES EDGAR CONOVER</u> 4. DATE OF DEATH <u>May 18th 1961</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 6th 1897</u> 9. AGE (in years last birthday) <u>63 yrs.</u> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.</p>											
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. U.S. Army</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>California, Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>											
<p>13. FATHER'S NAME <u>Charles Edgar Conover</u> 14. MOTHER'S MAIDEN NAME <u>Carrie Conover nee Carter</u></p>											
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>1917-1944</u> 17. INFORMANT <u>Ada J. Conover</u> Address <u>with Jane Conover (wife)</u></p>											
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery disease</u> (a), stating the underlying cause last. DUE TO (c)</p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</p>											
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)</p>											
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 18th 1961</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u> Address (Street, city, town, or county) <u>Forestville, Md.</u></p>											
<p>22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>May 22, 1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u></p>											
<p>23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 24a. REC'D BY REGISTRAR <u>May 19 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u></p>											

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Geteilte Conover des Caribäns

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5928  
CERTIFICATE OF DEATH

05917

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 3 yrs. 11 mo's			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1105- 5th St., S.E.			
3. NAME OF DECEASED (Type or print) Regina		First W		Last Cooper		4. DATE OF DEATH May 3 19 61	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/17/32	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses' Aide				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Cooper				14. MOTHER'S MAIDEN NAME Agnes ? Cooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ?		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 28, 1957, to May 3, 1961, that (I) (we) last saw the deceased alive on May 3, 1961, and that death occurred at 3P.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 5/3/61		22c. PHYSICIAN'S NAME (Type) Moe Weiss	
22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-9-1961		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City, town or county) (State) Huntsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Malvern + Schey Inc.				25a. REC'D BY REGISTRAR DATE MAY 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kinas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Information from birth cert.											
5929											
05919											
1. PLACE OF DEATH a. COUNTY <i>Prince George</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>				c. LENGTH OF STAY IN 1b				b. COUNTY <i>PG</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAP TOL Heights 26</i>				d. STREET ADDRESS <i>837 57th Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince George's General</i>				3. NAME OF DECEASED (Type or print) <i>BABY GIRL COWAN</i>				4. DATE OF DEATH Month <i>MAY</i> Day <i>26</i> Year <i>1961</i>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <i>MAY 26, 1961</i>		9. AGE (In years last birthday) yrs. <i>5</i>		IF UNDER 1 YEAR Months <i>5</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Pr. Geo's, Md.</i>			
13. FATHER'S NAME <i>John T. Cowan</i>				14. MOTHER'S MAIDEN NAME <i>Thelma Eileen Lamb</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Premature birth (2 lbs 3 oz)</i> <i>760.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Ateliosis</i> DUE TO (c) <i>Probable intracranial hemorrhage</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <i>a.m.</i> <i>19</i> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>MAY 26, 1961</i> to <i>MAY 26, 1961</i> , that (I) (we) last saw the deceased alive on <i>MAY 26, 1961</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Thomas A. Christensen</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>5/26/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>Dr. Thomas Christensen</i>				22d. ADDRESS <i>6905 BALTIMORE AVE, COLLEGE PARK, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>5-29-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prince Geo. Gen. Hospital</i>				23d. LOCATION (City, town or county) (State) <i>Cheverly, Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Penn, Jr.</i>				ADDRESS <i>2077 386 XVO</i>				25a. REC'D BY REGISTRAR DATE <i>JUN 2 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

IV

1



## CERTIFICATE OF DEATH

Reg. Dist. No. 05918

5930

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> p. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt 2 Box 78A</u>				d. STREET ADDRESS <u>1 Rt 2 Box 78A</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BERT</u> Middle <u>EDWARD</u> Last <u>CROSWELL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 25 1875</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (RET.) FARM</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>GEORGE W. CROSWELL</u>				14. MOTHER'S MAIDEN NAME <u>FOAMES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>DR. IN-LAW</u> Address <u>Rt 2 Box 78A CLINTON, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRO-VASCULAR ACCIDENT</u> 48 HRS. DUE TO <u>ARTERIOSCLEROTIC-CARDIOVASCULAR DISEASE</u> 10+ YRS. (c) <u>ARTERIOSCLEROTIC-CARDIOVASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u> 20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>NONE</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>NONE</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u> 20f. (City or town) <u>NONE</u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>APR. 1, 1961</u> to <u>Present</u> , that I last saw the deceased alive on <u>MAY 28, 1961</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Branch Ave., Clinton, Md.</u> DATE SIGNED <u>5/30/61</u> ACTUAL SIGNATURE <u>Arthur Shaver Jr., M.D.</u> PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. BRANCH AVE, CLINTON, MD. 5/30/61</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>6-1-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stowenton, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home - Wash.</u>				ADDRESS <u>  </u>		24a. REG. DAY REGISTRAR <u>  </u> DATE <u>JUN 2 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5931

05920

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margaret</b>				4. DATE OF DEATH <b>May 19 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 1, 1908</b>	
9. AGE (If years, birth day, Months, Days, Hours, Min.) <b>52 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick Magner</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>George John Curtis</b> Address <b>Same as Item #1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Massone Left Aortic Hemorrhage</b> <b>456 X</b> DUE TO (b) <b>Systemic Lupus Erythematosus</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 19 1961</b> to <b>May 19 1961</b> , that (I) (we) last saw the deceased alive on <b>May 19 1961</b> , and that death occurred at <b>8:30 PM</b> from the causes and on the date stated above.							
22. SIGNATURE <b>Max M. Herzberg</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>7016 Greig St. Seat Pleasant, Md.</b>		22b. DATE SIGNED <b>May 20, 1961</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Left wrist  
Lupus erythematosus

Lupus erythematosus

TO ~~DEPUTY~~ MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5932

05921

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Muirkirk</b>		b. COUNTY <b>Howard County</b>	
c. LENGTH OF STAY IN 1b <b>13 X-2</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #1, North of Muirkirk Underpass</b>		d. STREET ADDRESS <b>938 Lyon Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Henry (Harry)</b>		4. DATE OF DEATH <b>May 7th., 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 30th. 1909</b>	
9. AGE (In years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>52</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Inspector</b>		12. IF UNDER 24 HRS. Hours Min. <b>52</b>	
13. FATHER'S NAME <b>Peter J. Danesi</b>		14. MOTHER'S MAIDEN NAME <b>Fredericka Flack</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>062-03-5019</b>	
17. INFORMANT <b>Frances G. Danesi</b>		18. ADDRESS <b>Same as #2</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Myocardiosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 7th., 1961</b>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/10/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Burtonville Md</b>	
23. FUNERAL DIRECTOR <b>DeWitt Sandalson, Laurel, Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 15 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



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NAME: [illegible]  
ADDRESS: [illegible]  
CITY: [illegible]  
STATE: [illegible]  
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FOR: [illegible]  
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[illegible text continues in a structured format, possibly a form or report]





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Attention: May 10, 1953 at Lincoln County, North Carolina  
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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5934

05923

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FOR STATE  
HEALTH DEPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D. O. A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Heights</b> d. STREET ADDRESS <b>5615 Quincy</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Smith Alward Davis</b>			4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1961</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1949</b>		9. AGE (In years last birthday) <b>12</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Robert Taylor Davis</b>			14. MOTHER'S MAIDEN NAME <b>Julia Stender</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mr. Robert T. Davis, same as # 2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Crushed chest</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple abrasions of the hips</b>					INTERVAL BETWEEN ONSET AND DEATH		
19a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was riding bicycle that was in a collision with a tractor</b>					
20a. TIME OF INJURY Hour <b>12:05</b> p.m. Month, Day, Year <b>5/29/61</b>	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20d. (City or town) <b>Cheverly</b>	20e. (County) <b>P. G.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5/29/61</b> DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Colmar Manor, Md</b>		
23. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>			24a. REC'D BY REGISTRAR <b>JUN 2 '61</b> DATE				
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

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## MEDICAL CERTIFICATION

24b. REGISTRAR'S SIGNATURE  
Arthur S. Frank







# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5936

05925

1. PLACE OF DEATH a. COUNTY <b>Pr George</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr George.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2407 - Arundel Rd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt Rainier, Md.</b>		d. STREET ADDRESS <b>2407 Arundel Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>PAULINE J. DENGLER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25th.</b> Year <b>1961.</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/30/1873</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>48</b> Days <b>1</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>William Howard</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give year or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Emalir B. Sites</b>	
17. INFORMANT <b>Emalir B. Sites</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis of Lungs</b> <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma of Cecum</b> (c) <b>153.0</b> DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>about 1 mo.</b> <b>about 7 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>29 March 1961</b> , to <b>25 May 1961</b> , that (I) (we) last saw the deceased alive on <b>23 May 1961</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel Dove</b>		22b. DATE SIGNED <b>25 May 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL DOVE</b>		22d. ADDRESS <b>1801 Eye St. N.W. Washington D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/29/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakridge Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Altoona Pa</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home. - Washington D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 26 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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George's Cemetery

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Government of Canada  
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William Howard

Howells

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St. Helier, ad.

2407 - Arundel Rd.

St. George

2407 Arundel Rd.

St. Helier

Very Land

St. George

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# CERTIFICATE OF DEATH

Reg. Dist. No. 05926

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD. (D. C.)</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 21,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suitland Nursing Home</b>				d. STREET ADDRESS <b>5800 21 st Ave. S. E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>F.</b> Last <b>De Wald</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/19/1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Martin Fallon</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Margrobo Maygrove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Hospital records</b>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>332X</b> DUE TO <b>cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Generalized arteriosclerosis</b> DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-14</b> , 19 <b>56</b> , to <b>5-18</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5-16</b> , 19 <b>61</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2210 NICHOLS AVE S.E.</b> DATE SIGNED ACTUAL SIGNATURE <b>John B. Xegon</b> M.D. <b>WASH DC</b> PHYSICIAN'S NAME (Type) <b>JOHN B. FEGAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/22/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home, Washington, DC</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HO... AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5938											
05927											
1. PLACE OF DEATH a. COUNTY Prince George						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						b. COUNTY Prince George					
c. LENGTH OF STAY IN 1b 12 Hr.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS 4814 Delaware St.					
3. NAME OF DECEASED (Type or print) Lelia						4. DATE OF DEATH May 5 19 61					
5. SEX Female						6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Sept. 7, 1882					
9. AGE (In years last birthday) 78 yrs.						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					
11. BIRTHPLACE (County & State, or foreign country) Virginia						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Alfred Dunkum						14. MOTHER'S MAIDEN NAME Mary Haley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. no					
17. INFORMANT Mary Gee Long						Address Annandale Virginia					
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage 540.0 DUE TO Penetrating Gastric Ulcer Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 19....., to May 5....., 19.61 that (I) (we) last saw the deceased alive on 19.61 and that death occurred at 7 A.M. from the causes and on the date stated above.											
22a. SIGNATURE A. Del Tz											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) A. Del Tz											
22d. ADDRESS Hyattsville Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 5/8/61											
23c. NAME OF CEMETERY OR CREMATORY Arlington National											
23d. LOCATION (City, town or county) (State) Arlington Virginia											
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons											
ADDRESS Hyattsville, Md.											
25a. REC'D BY REGISTRAR DATE MAY 15 '61											
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus											

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... 3/8/61 ...

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... Virginia ...

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*[Handwritten signature and notes]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5939

## CERTIFICATE OF DEATH

05928

Item 9 Film 6288 5/26/61

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Rhode Island</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Providence</b> d. STREET ADDRESS <b>1146 Lester Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Michael</b> First <b>Dover</b> Last		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>14</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-14-1881</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Weaver</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Italy</b>
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <b>Louis Dover</b> Address <b>Lanham, Md.</b>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>no lobar pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5/14</b> , 19 <b>61</b> to <b>5/14</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>May 14</b> , 19 <b>61</b> , and that death occurred at <b>9:25 A.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>John KENOE</b> M.D.		<b>22b. DATE SIGNED</b> <b>5/14/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>John KENOE</b>		<b>22d. ADDRESS</b> <b>6300 RIVERDALE RD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Transportation</b>		<b>23b. DATE THEREOF</b> <b>May 15, 1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Providence</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 18 '61</b> DATE	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>		<b>25c. LOCATION</b> (City, town or county) (State) <b>Rhode Island</b>	

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F. Mason's one night's stay, N.Y.

Investigation of 10, 1961

State Police

JOHN KENNE

300 RIVERDALE RD

2 days

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05929

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITHAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUITHAND NURSING HOME T. #2 BOX 83</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LORA R. DRYDEN</u>			4. DATE OF DEATH Month Day Year <u>MAY 17 1961</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-12-1895</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MILLS H. DRYDEN</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Long</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #1.</u>		17. INFORMANT Address <u>NURSING Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized metastasis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 2 1961</u> to <u>May 17 1961</u> , that (I) (we) last saw the deceased alive on <u>MAY 17 1961</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo H. Mugmon</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leo H. Mugmon M.D.</u>				22d. ADDRESS <u>2711-GAITHER ST. SE. HILLCREST 19118</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>May 19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS HOPE RD SE</u>				25a. REC'D BY REGISTRAR <u>1661 GOOD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CENTRAL DEATH

DATE

NAME

RESIDENCE

SEX

AGE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF PHYSICIAN

NAME OF BURIAL PLACE

DATE

NAME

SEX

AGE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF PHYSICIAN

NAME OF BURIAL PLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 8 & 9 Film G288 5/29/61 mh

5941

05930

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md.</b> c. LENGTH OF STAY IN b <b>4803 69th Place</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b> d. STREET ADDRESS <b>4803 69th Place,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Randolph Henry Duff</b> First Middle Last			4. DATE OF DEATH <b>May 21, 1961-19</b> Month Day Year		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1899</b> Ma		9. AGE (In years last birthday) <b>62</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Instructor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>University of Md</b>		11. PLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>John Edward Duff</b>		
14. MOTHER'S MAIDEN NAME <b>Gibson</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>no</b>			17. INFORMANT <b>Mildred Sherman Duff</b> Address <b>Hyattsville Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>June</b>		20g. (County) <b>May 21, 1961</b>		20h. (State) <b>that (I) (we) last</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> to <b>May 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1961</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>William D Rosson</b> M.D.			22b. DATE SIGNED <b>5/21/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>William D Rosson</b>			22d. ADDRESS <b>5510 Madison St Riverdale, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 23, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	
23d. LOCATION (City, town or county) <b>Colmar Manor, Md.</b>		23e. REC'D BY REGISTRAR <b>MAY 24 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>					

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FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5942

65931

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>L hour</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Delaware</b>		b. COUNTY <b>Wilmington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>		d. STREET ADDRESS <b>900 Marble Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Richard</b>		Middle <b>Michael</b>		Last <b>Duffy</b>		4. DATE OF DEATH <b>May</b>		Month <b>3</b>		Day <b>19</b>		Year <b>61</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1941</b>		9. AGE (In years last birthday) <b>20</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>University of Md</b>				11. BIRTHPLACE (State or foreign country) <b>Delaware</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles Edward Duffy</b>				14. MOTHER'S MAIDEN NAME <b>Florence Stidham</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Duffy</b> <b>Charles E. Duffy, same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Gum shot wound of the head</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Place revolver against right cheek and pulled the trigger</b>															
20c. TIME OF INJURY Month, Day, Year <b>7:45 p.m. 5/3 1961</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Dormitory</b>				20f. (City or town) <b>College Park P. G.</b>				20g. (County) <b>Md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																			
ACTUAL SIGNATURE <b>James I. Boyd</b>				M.D. <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				DATE SIGNED <b>5/3/61</b>				Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 8, 1961</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Wilmington, Delaware</b>							
23. FUNERAL DIRECTOR <b>William F. Jones</b>				ADDRESS <b>Claymont, Delaware</b>				24a. REC'D BY REGISTRAR <b>MAY 10 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. ATSMC  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5943

Item 8 & 9 Film G207 5/15/61 iwb

05932

1. PLACE OF DEATH e. COUNTY <u>Prince George's</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1113</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dobson Clinic</u>		d. STREET ADDRESS <u>RF. D.</u>	
3. NAME OF DECEASED (Type or print) <u>Flora Arnold Hunbar</u>		4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1916</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>	11. BIRTHPLACE (State or foreign country) <u>South Dakota U.S.A.</u>
13. FATHER'S NAME <u>Roy Hunbar</u>		14. MOTHER'S MAIDEN NAME <u>Muriel Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>408-12-3753</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY INSUFFICIENCY</u> DUE TO (b) <u>SEVERE CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>HYPERTENSIVE HEART DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/12/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or country) (State) <u>Lamoni, Iowa</u>
23. FUNERAL DIRECTOR <u>Archart Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 10 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

NO. 1111

11

1

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY MEDICAL DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5944

Items 8, 9 & 14 Film G288 5/31/61 iwk

05933

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>8 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> d. STREET ADDRESS <b>11012 Mont. Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emma</b>		First <b>W</b>		Last <b>Eberle</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-6-77/ 1878</b>	
9. AGE (in years last birthday) <b>82/43 yrs.</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Norwood P Glading</b>				14. MOTHER'S MAIDEN NAME <b>Anna Coombs</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Anna M Funk</b>				Address <b>Lanham, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>was due to S. I hemorrhage</b> <b>541.0</b> DUE TO (b) <b>blue dental ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>2 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 18</b> , 19 <b>61</b> , to <b>May 18</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>May 18</b> , 19 <b>61</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>T. R. Bergemann</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Till Bergemann</b>				22d. ADDRESS <b>3-D Crescent Road, Greenbelt, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 22, 1961</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 23 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



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any in, just in case, in case

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
5945 Item 8 Film G266 5/8/61 iwk 65934															
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>25 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>105 78th St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Franklin W Fairbanks</b>			4. DATE OF DEATH <b>May 2 19 61</b>			9. AGE (In years last birthday) <b>80 yrs.</b>			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 25, 1881</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk B. &amp; M. Rail Road</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Fairbanks</b>						14. MOTHER'S MAIDEN NAME <b>Delia A. Godding</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>William H. Fairbanks</b>		Address <b>Same as # 2 (Son)</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute thrombosis of coronary artery</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic coronary artery disease</b> (c) <b>10 years</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Thrombosis of cerebral artery</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <b>April 8</b> , 19 <b>61</b> to <b>May 2</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>May 2</b> , 19 <b>61</b> , and that death occurred <b>5:35 p.m.</b> on the causes and on the date stated above.															
22a. SIGNATURE <b>Peter Davis</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS									
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>5/5/61</b>				23b. DATE THEREOF <b>5/5/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Woodmont Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>East Burke Vermont</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F; Gasch's Sons</b>						ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>					

(M)

(I)

W. D. Jones's Sons, Lynchville, Va.

Woodmont Cemetery

1871

1871

1871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5946

Item 13 Film 8288 6/15/61 jwr

05935

1. PLACE OF DEATH e. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> h. COUNTY <b>30014</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 17</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LAUREL SANITARIUM</b>		d. STREET ADDRESS <b>LAKE DRIVE APTS</b>	
3. NAME OF DECEASED (Type or print) <b>HELEN TERDENHEIMER</b>		4. DATE OF DEATH <b>5 12 19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>85</b>
11. BIRTHPLACE (County & State, or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Feldenheimer</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE ROTHSCHILD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Hosp. Records LAUREL SANITARIUM</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X Apoplexy (334)</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>June 12-19-53</b> to <b>5-12-1961</b> that (we) last saw the deceased alive on <b>5-12-1961</b> , and that death occurred at <b>930A</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Linda P. Kraemer</b> M.D.		22b. DATE SIGNED <b>5-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>		22d. ADDRESS <b>Laurel Sanitarium Laurel Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-15-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		23d. LOCATION (City, town or county) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>		25. REC'D BY REGISTRAR <b>MAY 15 '61</b>	
ADDRESS <b>2100 Euteria Place</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

(M)

PRINCE GEORGE

WARRINGTON

1915-19-23

BASTIMORE 17

PAUL JANTARIN

LAKE DRIVE 17

HELEN

FEEDBACHER

4-1-1936 82

ROMARE WHITE

more

MORT GARCIA N.Y.

ERIE ROTHCHILD

HOP. RECORDS JAMES JANTARIN

Thompson (1914)  
unlike contemporary  
X

4 days  
8 years  
X

(1915-19-23) 4-11-36 61

61 8-12-36

ERIE P. JANTARIN

X

ERIE P. KREMER, James J. JANTARIN, June 1915

June 1915  
James J. JANTARIN  
ERIE P. KREMER  
June 1915



## CERTIFICATE OF DEATH

Reg. Dist. No.

05936

5947

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>8 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11305 MONTGOMERY ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMALINE</u> Middle <u>—</u> Last <u>FEHRMANN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Spencer Hale</u>		14. MOTHER'S MAIDEN NAME <u>Not Available</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Jane Funkhouser</u>		Address <u>7604 Glenview Dr. T.P. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE CARDIAC DECOMPENSATION</u> DUE TO <u>1 M.D.</u> (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO <u>1 P.M.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT</u> , 19 <u>60</u> , to <u>5-25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>61</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. B. Baker M.D.</u>		ADDRESS (Street, city or town, state) <u>2513 BULKHEAD RD.</u> DATE SIGNED <u>5-25-61</u>	
PHYSICIAN'S NAME (Type) <u>R.D. BAKER, M.D.</u>		<u>BALTIMORE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 29, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW DC</u>	
24a. REC'D BY REGISTRAR <u>MAY 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinsey</u>	

TO HO: 1. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1918



FILED

Blank form with horizontal lines for text entry.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
5948										
05957										
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS			c. LENGTH OF STAY IN 1b 15 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OXON HILL			d. STREET ADDRESS 4800 KIRBY HILL ROAD		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL, ANDREWS AFB MD					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE MARIE FINK					4. DATE OF DEATH Month Day Year MAY 31 19 61					
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 16, 1899		9. AGE (In years last birthday) 61 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHARLES HENRY FINK					14. MOTHER'S MAIDEN NAME GERTRUDE MARIE MILLER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 176-05-0838		17. INFORMANT Address DOROTHY F MILLER, 4800 KIRBY HILL RD WASH 22 DC						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANASARCA; HEPATIC; RENAL DISEASE DUE TO (c) DIABETES								INTERVAL BETWEEN ONSET AND DEATH 1 MONTH UNKNOWN		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from 16 MAY 19 61 to 31 MAY 19 61, that (I) (the hospital) last saw the deceased alive on 31 MAY 19 61, and that death occurred at 3:10A M, from the causes and on the date stated above.										
22a. SIGNATURE Shane B. Mahon 22c. PHYSICIAN'S NAME (Type) CHARLES B MAHON, CAPT, USAF, MC					22b. DATE SIGNED 31 MAY 1961 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) C			23b. DATE THEREOF 6/2/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION (City, town or county) (State) Hanover Pa. York Co.			
24. FUNERAL DIRECTOR'S SIGNATURE Friedrich Bucher					ADDRESS Hanover Pa		25a. REC'D BY REGISTRAR DATE JUN 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Mahon	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5949

Item 8 Film G288

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05938

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>E</b> Last <b>Foreman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 4 1890</b>
9. AGE (In years last birthday) <b>72</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel Steinour</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Fleming</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Charles H Foreman Sr Hyattsville, Md.</b>	
17. INFORMANT <b>Charles H Foreman Sr Hyattsville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO <b>thrombosis, left vent.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Arteriosclerosis of the heart</b> DUE TO <b>15 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>May 21, 1961</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert Roth</b>		22b. DATE SIGNED <b>May 21, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Albert Roth, M.D.</b>		22d. ADDRESS <b>5510 Madison St., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 24, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>MAY 26 '61</b>	
ADDRESS <b>Hyattsville Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5950

05939

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3. VO 1-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>General Prince George's Hospital</b>		1515 Paterson Park Ave		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willie J Foster</b>		First Middle Last		4. DATE OF DEATH <b>May 6, 1961</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH <b>8-31-1934</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Track Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Blackstock, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Foster</b>		14. MOTHER'S MAIDEN NAME <b>Josephine McDowell</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>250-52-4559</b>	
17. INFORMANT <b>Josephine Foster</b>		Address <b>R-2 Box Blackstock, S.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO <b>fracture of left hip, dislocation</b> DUE TO <b>multiple fracture of mandible</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Occupant of an automobile that was in an head on collision</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>collision</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year <b>8:25 p.m. April 27/61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Muirkirk P. G. Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D.		DATE SIGNED <b>May 6, 1961</b>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5-11-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Radio Baptist Cemetery Woodward, S.C.</b>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>Randolph H. Collier</b>		ADDRESS <b>1412 E. Preston St.</b>		24a. REC'D BY REGISTRAR <b>MAY 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5951

05940

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Compton, Md.</b> d. STREET ADDRESS <b>St. Clement's Shores</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Kate M Freeman</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>May 7 19 61</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 6, 1881</b>
<b>9. AGE</b> (In years last birthday) <b>80 yrs.</b>		<b>10. BIRTHPLACE</b> (County & State, or foreign country) <b>Penna.</b>	
<b>11. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>D. J. McAdam</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Kate Wishart</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>John D. Freeman 6202 Shadyside Rd. Capitol Hgt.</b>	
<b>17. INFORMANT</b> <b>Kate Wishart</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular hemorrhage</b> DUE TO <b>321X</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral arteriosclerosis</b> DUE TO <b>Unborn</b> (c) <b>Unborn</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from May 4, 19 61 to May 7, 19 61, that (I) (we) last saw the deceased alive on May 7, 19 61, and that death occurred at 8:10 p.m. the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>John Kehoe</b> <b>JOHN KEHOE, M.D.</b> <b>6300 RIVERDALE RD.</b>		<b>22b. DATE SIGNED</b> <b>5/8/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THIS DEATH CERTIFICATE FILED</b> <b>May - 10 - 61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Pauli</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Leonardtown Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Charles Mattingly</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 15 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5952

05942

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges. MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Adelphi 1st mos. c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paint Branch Nursing Home				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Terra Alta c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Terra Alta d. STREET ADDRESS 502 State St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>3. NAME OF DECEASED</b> (Type or print) Joseph (None) Glover		<b>4. DATE OF DEATH</b> Month May Day 23 Year 1961		<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> June 24, 1872		<b>9. AGE</b> (In years last birthday) 88 yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>11. IF UNDER 24 HRS.</b> Months Days Hours Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Painter				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Private Business				<b>11. BIRTHPLACE</b> (County & State, or foreign country) Preston Co., W. Va.				<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.											
<b>13. FATHER'S NAME</b> Preston Glover				<b>14. MOTHER'S MAIDEN NAME</b> Selina Millard				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No				<b>16. SOCIAL SECURITY NO.</b> None				<b>17. INFORMANT</b> Nursing Home Records							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure, Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH One week																							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from February 10, 1960, to 5-22, 1961, that (I) (we) last saw the deceased alive on May 16, 1961, and that death occurred at 8:30 AM, from the causes and on the date stated above.																							
<b>22a. SIGNATURE</b> Stuart L. Nelson				<b>22b. DATE SIGNED</b> 5-22-61				<b>22c. PHYSICIAN'S NAME</b> (Type) Francis Gasch's Sons				<b>22d. ADDRESS</b> Hyattsville, Md.				<b>22e. REC'D BY REGISTRAR</b> MAY 25 '61				<b>22f. REGISTRAR'S SIGNATURE</b> Arthur L. Hume			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial				<b>23b. DATE THEREOF</b> 5/26/61				<b>23c. NAME OF CEMETERY OR CREMATORY</b> Terra Alta Cemetery				<b>23d. LOCATION</b> (City, town or county) Terra Alta, West Virginia (State)											

(M)

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **05943**

5953

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>			
c. LENGTH OF STAY IN 1b <b>42 years</b>				d. STREET ADDRESS <b>-----</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-----</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Maude</b> Last <b>Goldsmith</b>				4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 4, 1898</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John F. Goldsmith</b>				14. MOTHER'S MAIDEN NAME <b>Ada Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>			
17. INFORMANT <b>James H. Goldsmith--Brandywine, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Denialy Cor and Renal Dis</b> DUE TO (c) <b>Age 63</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>5-10</b> , 19 <b>56</b> , to <b>5-17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5-17</b> , 19 <b>61</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brandywine, Maryland</b> DATE SIGNED <b>5/17/61</b>							
ACTUAL SIGNATURE <b>Richard H. Dobson, M.D.</b>				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/20/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baden Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home--Upper Marlboro Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

STATE OF MARYLAND

COUNTY OF BALTIMORE

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF PHYSICIAN

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF COURT

SIGNATURE OF STATE

SIGNATURE OF COUNTY

SIGNATURE OF CITY

SIGNATURE OF TOWN

SIGNATURE OF VILLAGE

SIGNATURE OF POST OFFICE

**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY in 1b <b>D.O.A.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				d. STREET ADDRESS <b>6300 Jocelyn</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>												
<b>3. NAME OF DECEASED</b> (Type or print) <b>Monica Ann Grace</b>						<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>10</b> , Year <b>1961</b>						
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 6, 1959</b>		<b>9. AGE</b> (In years last birthday) <b>2</b> yrs. <div>             IF UNDER 1 YEAR              Months _____ Days _____           </div>		IF UNDER 24 HRS. Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		
<b>13. FATHER'S NAME</b> <b>Raymond James Grace</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Helen Patterson</b>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Paul R. Grace</b>		<b>3735 Camden Street S. E.</b> <b>Washington D.C.</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <div> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Hemorrhage and shock</b>  <b>812X</b> <b>DUE TO</b>  <b>Conditions, if any, which gave rise to immediate cause (b)</b> <b>Fractured base of the skull</b>  <b>(e), stating the underlying cause last.</b> <b>DUE TO</b>  <b>(c)</b> </div>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>												
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by an automobile</b>								
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>15</b> Hours <b>10:15</b> p.m. <b>5/10/61</b>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		<b>20f. (City or town)</b> <b>Cheverly</b>		<b>(County)</b> <b>P. G.</b>		<b>(State)</b> <b>Md</b>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>												
<b>ACTUAL SIGNATURE</b> <b>James I. Boyd</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						
<b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd</b>						<b>DATE SIGNED</b> <b>May 10, 1961</b>						
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>May 13/61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Elvies</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>Wash. D.C.</b>				
<b>23. FUNERAL DIRECTOR</b> <b>J. F. Costello</b>						<b>ADDRESS</b> <b>1722 N. Capitol</b>		<b>24a. REC'D BY REGISTRAR</b> <b>MAY 12 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. House</b>		



Received of Mr Wm H. Barker  
the sum of £100.00

2.3. 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
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65945  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Pr. George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Hgts.</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5804 - 24th Pl.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Pr George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Hgts.</b> d. STREET ADDRESS <b>5804 - 24th Pl.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DENNIS</b> First Middle Last <b>Gray</b>		4. DATE OF DEATH <b>May 31st. 1961.</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1886</b> 9. AGE (In years last birthday) <b>74</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Fire Dept.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Andrew E Gray</b>	
14. MOTHER'S MAIDEN NAME <b>Josephine E Brown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>no</b> 17. INFORMANT <b>Mrs Dorothy Williams -same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Complete heart block</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b> <b>11</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 19, 1960</b> to <b>May 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 22, 1960</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank J Talbot</b>		22b. DATE SIGNED <b>May 31, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank J Talbot</b>		22d. ADDRESS <b>5607 14th Ave Hillcrest Hgts, Md</b>	
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF <b>6-3-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d. LOCATION (City, town or county) (State) <b>Suitland Md.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUN 2 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

(M)

St. George

Minister of State

1880 - 1881

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White

Native

Andrew E. Gray

(I)

U.S. Life Dept.

U.S.

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1880 - 1881

The following information is given

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Frank J. Lippert

6-3-61

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George Hill

1881

See - United States Washington, D.C.



## CERTIFICATE OF DEATH

Reg. Dist. No. 05946

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARLOWE HEIGHTS 1 VR.</b>		c. LENGTH OF STAY IN 1b <b>18 MARLOWE HEIGHTS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6058-28th AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LULU (LULA) MAE GREEN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>AMER. INDIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 4-1904</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>Days</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WEST VA.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>ELI MOYTS</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA (UNKNOWN)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-36-7333</b>	
17. INFORMANT <b>EDGAR GREEN</b>		Address <b>6058-28th AVE. MARLOWE HTS. MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1 INANITION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOGENIC CARCINOMA -</b> DUE TO <b>RT. LUNG WITH EXTENSIVE METASTASES</b> (c) <b>9 MOS.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>NONE</b> 19 <b>61</b>	20d. INJURY OCCURRED While at work <b>NONE</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>	20f. (City or town) (County) (State) <b>NONE</b>
21. I certify that I attended the deceased from <b>AUGUST 1960</b> , to <b>PRESENT</b> , that I lost the deceased on <b>MAY 22, 1961</b> , and that death occurred at <b>4:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Branch Ave. Clinton Md.</b> DATE SIGNED <b>5/30/61</b>			
ACTUAL SIGNATURE <b>Arthur Shaver Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. BRANCH AVE. CLINTON, MD. 5/30/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/1/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wash. National</b>	22d. LOCATION (City, town, or county) (State) <b>Southland Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. 517 11th St. S.E. Wash.</b>		24a. REC'D BY REGISTRAR <b>JUN 1 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



(M)

THIS IS TO CERTIFY THAT on the \_\_\_\_\_ day of \_\_\_\_\_ 1908, at \_\_\_\_\_  
in the County of \_\_\_\_\_ State of \_\_\_\_\_, \_\_\_\_\_  
aged \_\_\_\_\_ years, \_\_\_\_\_  
sex \_\_\_\_\_, \_\_\_\_\_  
cause of death \_\_\_\_\_  
\_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5957

65947

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b> d. STREET ADDRESS <b>7450 Livingston Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eugene (N.M.N.)</b>		4. DATE OF DEATH <b>May 13 1961</b>		5. AGE (In years last birthday) <b>71</b>	
6. SEX <b>Male</b>		7. COLOR OR RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>715</b>		17. INFORMANT <b>William Grove</b> Address <b>7111 - Palmer Rd. S.E.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> 331X DUE TO (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>E. V. A.</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Prince George</b>		20g. (County) <b>Prince George</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1961</b> , to <b>May 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 13, 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Max M. Herzberg</b>		22b. ADDRESS <b>7016 - Leig St. Seat Pleasant Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>MAX M. HERZBERG</b>	
22d. ATTENDING PHYS. <input checked="" type="checkbox"/>		22e. MED. DIRECTOR <input type="checkbox"/>		22f. STAFF PHYS. <input type="checkbox"/>	
22g. DATE <b>MAY 17 '61</b>		22h. SIGNATURE <b>Arthur S. Kraus</b>		22i. DATE <b>MAY 17 '61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Em.</b>	
23d. LOCATION (City, town or county) <b>Oxon Hill Md.</b>		23e. (State) <b>Md.</b>		23f. (Country) <b>U. S. A.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers &amp; Inc.</b>		24a. ADDRESS <b>577-11 St. S.E.</b>		24b. CITY <b>D.C.</b>	

VR A15 (4)  
15M 9/60

III

I

7:30 a.m.

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9/60

(M)

(I)

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>5958</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>05948</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D. O. A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>6904 Old Landover Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Kenton Lee Harris</b>				<b>4. DATE OF DEATH</b> <b>May 25 1961</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 2, 1944</b>		<b>9. AGE</b> (In years last birthday) <b>16</b> yrs. <div>             IF UNDER 1 YEAR              Months Days           </div>		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>School</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Henry Franklin Harris</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Virginia Grace Trotter</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>XXXX-219-42-2575</b>				<b>17. INFORMANT</b> <b>Virginia Grace Harris, same as # 2</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <div> <div> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Hemorrhage and shock</b>  <b>976X</b>  <b>976X</b> </div> <div> <b>DUE TO</b>  <b>(b)</b> <b>Gun shot wound of the head</b>  <b>DUE TO</b>  <b>(c)</b> </div> </div> <div> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </div>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in the head</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>6:30 a.m. 5/25/61</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>20f. (City or town)</b> <b>Landover</b>		<b>(County)</b> <b>P. G.</b> <b>(State)</b> <b>Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>5/25/61</b>			
<b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>Address</b> (Street, city, town, or county)											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>5-29-61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Natl Mem Park Cem</b>				<b>22d. LOCATION</b> (City, town, or country) <b>Falls Church, Virginia</b>			
<b>23. FUNERAL DIRECTOR</b> <b>W.W. Chambers Co</b>						<b>24a. REC'D BY REGISTRAR</b> <b>May 31 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. House</i>			

14

1

1

THE STATE OF NEW YORK  
IN SENATE  
January 14, 1914  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1913  
ALBANY: J.B. LEECH, STATE PRINTER, 1914.

ALBANY: J.B. LEECH, STATE PRINTER, 1914.



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05949

1. PLACE OF DEATH e. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Glenn Dale, Md.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>4 yrs. 2 mos.</b>		d. STREET ADDRESS <b>1819 East Capitol Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THELMA T. HILL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>separated</b>	8. DATE OF BIRTH <b>Feb. 18, 1921</b>
9. AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fountain Girl</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willington Fletcher</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Boston</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Deceased</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far Advanced</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO <b>002x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Thoracoplasty; Cor pulmonale</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 18, 1957</b> , to <b>May 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1961</b> , and that death occurred at <b>350p</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>May 19, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/26/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. E. Jarvis Co.</b>		25a. REC'D BY REGISTRAR <b>MAY 23 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

2263

Prison, Georgia

Local, Glenn Dale, Md.

Glenn Dale Hospital

Prison

W.

WILL

May

19

61

1919 East Capitol Street

Washington, D.C.

District of Columbia

Prison

Prison

Prison

Prison, 18, 1921

Washington, D.C.

Prison

Prison

Prison, 18, 1921

Prison, 18, 1921

Prison

Prison

Prison

Prison, 18, 1921

Prison, 18, 1921

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Prison, 18, 1921

Prison, 18, 1921

Prison, 18, 1921

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5960

## CERTIFICATE OF DEATH

Item 9 Film G288 6/7/61 ink

45950

1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Glenn Dale (rural)

c. LENGTH OF STAY IN 1b

27 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE

D. C.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

810 6th St., N. W.

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)

First

Yoke

Middle

Sang

Last

Hor

## 4. DATE OF DEATH

Month

5

Day

29

Year

19 61

5. SEX

Male

6. COLOR OR RACE

Chinese

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

5/9/1882

9. AGE (In years last birthday)

79 7/8 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10b. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (County &amp; State, or foreign country)

China

12. CITIZEN OF WHAT COUNTRY?

China

13. FATHER'S NAME

Ting Yu Hor

14. MOTHER'S MAIDEN NAME

Eng Shee Hor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Unknown

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Decedent

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Massive pulmonary hemorrhage

INTERVAL BETWEEN ONSET AND DEATH  
7 minutes

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Far advanced pulmonary tuberculosis

3 yrs., 10 mo.

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Diabetes mellitus; para-aminosalicylic acid hypersensitivity

Microscopic exam. found bronchogenic carcinoma, undifferentiated type

19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.  
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5/2/1961 to 5/29/1961, that (I) (we) last saw the deceased alive on 5/29/1961, and that death occurred at 5:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Moe Weiss

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☒

STAFF PHYS.

22b. DATE SIGNED

5/29/1961

22c. PHYSICIAN'S NAME (Type)

Moe Weiss, M. D.

22d. ADDRESS

Glenn Dale Hospital  
Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

6/1/61

23c. NAME OF CEMETERY OR CREMATORY

Geo. Washington Memorial

23d. LOCATION (City, town or county)

Hyattsville, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. W. Chambers &amp; Co. Riverdale, Md. 752

25a. REC'D BY REGISTRAR

JUN 5 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/60

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*Wm. L. L.*

*Wm. L. L.*

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VR A15 (4)  
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Rainier, Md.</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Rainier Md.</b>		d. STREET ADDRESS <b>3204 Otis Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3204 Otis Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Lillian</b> Last <b>Hughes</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of hospital life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William T Cardle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Snuggs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>242012655</b>	
17. INFORMANT <b>Dorise Jackson</b>		Address <b>Mt. Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>15 Min.</b> <b>10 yrs. +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1949 - 1949</b> to <b>6 May 1961</b> , that (I) (we) last saw the deceased alive on <b>6 May 1961</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Jules Gilbert</b>		22b. DATE SIGNED <b>5/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jules Gilbert. MD</b>		22d. ADDRESS <b>3200 CHILLUM Rd. Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation 5/8/61</b>		23b. DATE THEREOF <b>5/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Charlotte</b>		23d. LOCATION (City, town, or county) (State) <b>North Carolina Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>MAY 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lewisdale</i>		c. LENGTH OF STAY IN 1b <i>58</i> years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2015 Beechwood Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>CARL</i> Middle <i>W.</i> Last <i>HUHNDOCKFF</i>		4. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 22, 1905</i>
9. AGE (In years last birthday) <i>55</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Research Director</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Int. Assoc. of Machine Tools</i>	
11. BIRTHPLACE (State or foreign country) <i>San Antonio, Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Karl Huhnrock</i>		14. MOTHER'S MAIDEN NAME <i>Alma Mueller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>454-10-8567</i>	
17. INFORMANT Address <i>Mr. Gladys R. Huhnrock (same as #2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Lung</i> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 11, 1961</i> to <i>May 3, 1961</i> , that (I) <del>(was)</del> lost saw the deceased alive on <i>May 3, 1961</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Ronald S. Fleischer</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5-3-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>RONALD S. FLEISCHER</i>		22d. ADDRESS <i>907 SHERIDAN ST. HYATTSVILLE, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 6, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW. DC</i>		25. REC'D BY REGISTRAR <i>MAY 8 '61</i>	
26. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.  
JANUARY 1, 1900

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65953

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		c. LENGTH OF STAY IN 1b <b>6 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant, Maryland 28</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6337- Rollins Ave., S.E.</b>				d. STREET ADDRESS <b>6337- Rollins Ave., S.E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JAMES W. HURTT SR.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>31st</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 14- 1889</b>		9. AGE (In years lost birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Maurice Hurtt</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lanham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>226-07-1813</b>		17. INFORMANT <b>James W. Hurtt, Jr. Same as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Prostate &amp; Extension</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1961</b> to <b>May 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1961</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J. H. Thibadeau</b>				22b. DATE SIGNED <b>May 31 5T 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH H. THIBADEAU</b>				22d. ADDRESS <b># 3112- Ala. Ave., S.E. Washington, DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 3rd 61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Bros.</b>				ADDRESS <b>1661- Good Hope Rd S.E. Wash. DC.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

CERTIFICATE OF DEATH

(VI)

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of death: [illegible]



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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5964											
05954											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>						c. LENGTH OF STAY in 1b <u>6 days</u>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>						d. STREET ADDRESS <u>200 R.I. Ave. N.E.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>EVA CATHERINE Hussey</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>23</u> Year <u>1961</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-30-94</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DuBoise, Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jack Gardner</u>						14. MOTHER'S MAIDEN NAME <u>Cora Kirchartz</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>None</u>						16. SOCIAL SECURITY NO. <u>174-14-4292</u>					
17. INFORMANT <u>Mr. Myrl T. Hussey, Ave., N.E., Wash. 2, D.C.</u>						Address <u>200 Rhodes Island</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pancreatic necrosis</u> DUE TO <u>199X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute Intestinal Obstruction</u> (c) <u>metastatic Carcinoma</u> DUE TO <u>2 yr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 18, 1961</u> , to <u>MAY 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>MAY 23, 1961</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul Schwartz</u> M.D.						22b. DATE SIGNED <u>MAY 23, 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>DR. PAUL SCHWARTZ</u>						22d. ADDRESS <u>1726 Eye St. N.W. Washington, D.C.</u>					
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>				23b. DATE THEREOF <u>May 26, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>						25a. REC'D BY REGISTRAR <u>5801 Cleveland Ave. Riverdale</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>						DATE <u>MAY 25 '61</u>					

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

202-451-7171

THE UNIVERSITY OF CHICAGO

1992-1993

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5965

65955

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Prince George's</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
c. LENGTH OF STAY in 1b <u>15 days</u>		d. STREET ADDRESS <u>Prince George's General Hospital/old Baltimore Pike</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Gertrude</u>		<b>4. DATE OF DEATH</b> <u>MAY 23</u> 19 <u>61</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-8-99</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own Home</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>
<b>13. FATHER'S NAME</b> <u>Samuel Ingram</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Cindy Collins</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>17. INFORMANT</b> <u>Gordon Ingram</u> Address <u>Beltsville, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 420.0 DUE TO <u>Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAY 7</u> , 19 <u>61</u> , to <u>MAY 23</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5-23</u> , 19 <u>61</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>George Hagarage</u> M.D.		<b>22b. DATE SIGNED</b> <u>5-23-61</u>	<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. George Hagarage</u>
<b>22d. ADDRESS</b> <u>3717 38th AVE Cottage City, Md</u>		<b>22e. REC'D BY REGISTRAR</b> <u>May 26 '61</u>	
<b>22f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	
<b>23b. DATE THEREOF</b> <u>May 25, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bellsvalley Methodist Rockridge Co Va</u>	
<b>23d. LOCATION</b> (City, town or county) (State)		<b>23e. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Pasche sons Hyattsville Md</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

VR A15 (4)  
15M 9/60

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Handwritten notes and signatures, including "B. J. ...", "J. ...", and "J. ...".

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5966 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: <u>Maryland</u> b. COUNTY: <u>Prince George's</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>						c. LENGTH OF STAY IN 1b <u>4 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>						e. STREET ADDRESS <u>15925 - 28th Ave</u>					
3. NAME OF DECEASED (Type or print) <u>Lillie Blanche Ireland</u>						4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME <u>Thomas Watson</u>						14. MOTHER'S MAIDEN NAME <u>Selma Melissia VanHess</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>141-09-0581</u>		17. INFORMANT <u>William C. Amstrong, same as #</u>			
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 903.0 DUE TO (b) <u>Fracture of right hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor and fractured right hip</u>					
20c. TIME OF INJURY Month, Day, Year <u>11 a.m. 5-24-61</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Marlow Heights PG</u>	
21. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED <u>5-28-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>May 31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East Ridge Lawn Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Delawanna New Jersey</u>	
23. FUNERAL DIRECTOR <u>Simmons Bros.</u>						ADDRESS <u>1661 - Good Hope Rd SE WASH. DC</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Frank</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	
						DATE <u>MAY 31 '61</u>					



WFOCAL: EXAMINER: CERTIFICATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and they must be filed within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5967

05957

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Tina Louise Jackson</b>		d. STREET ADDRESS <b>Route 2 Box 2109</b>	
4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 61</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>8</b> yrs. IF UNDER 1 YEAR Months <b>2</b> Days <b>5</b> IF UNDER 24 HRS. Hours <b>55</b> Minutes <b>55</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Milton Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Rose Agnes Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mother</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (1 lb 3 oz)</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Asphyxia</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 3, 19 61</b> to <b>May 5, 19 61</b> that (I) (we) last saw the deceased alive on <b>May 4, 19 61</b> , and that death occurred at <b>9:55 A.M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas A. Christensen</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen. M.D.</b>		22d. ADDRESS <b>6501 Baltimore Ave., College Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cheverly, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr. Adm.</b>		25a. REC'D BY REGISTRAR <b>MAY 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 287 5-19-61											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlow Heights c. LENGTH OF STAY IN lb. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parking Lot Hecht's Dept. Store.						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights d. STREET ADDRESS 6011 27th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Walter Joseph Jarvis First Middle Last						4. DATE OF DEATH May 11, 1961 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1919		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator				10b. KIND OF BUSINESS OR INDUSTRY Potomac Power Co.				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jarvis						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII				16. SOCIAL SECURITY NO. 577-38-6869		17. INFORMANT Mrs Margaret Jarvis, same as # 2 Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA 921.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) ASPIRATION, GASTRIC CONTENTS (c) DUE TO (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FATTY Degeneration, liver 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspiration stomach contents (Had a high blood alcohol 400.%) in trachea and bronchi							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 5-11-1961 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking lot		20f. (City or town) Marlow Hgts. P.Geo. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED May 11, 1961. Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 5/16/61		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.				22d. LOCATION (City, town, or country) (State) Ft. Myer Va.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Maryland.						24a. REC'D BY REGISTRAR MAY 15 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

Form with multiple sections and fields, including a header section with a title, a main body with various input fields and checkboxes, and a footer section. The form is oriented horizontally but contains vertical text in some areas.

**Header Section:**

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- Section 2: [Illegible text]
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**Main Body:**

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

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I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
5969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65959												
1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Florida b. COUNTY Dade							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami Beach							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 1150 100 th Street							
3. NAME OF DECEASED (Type or print) Joseph Abraham Kanter					4. DATE OF DEATH May 4, 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1892		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant					10b. KIND OF BUSINESS OR INDUSTRY Food			11. BIRTHPLACE (State or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Kanter					14. MOTHER'S MAIDEN NAME Hilda							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 138-02-3639		17. INFORMANT Mrs Regina E. Kanter, same as # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5/4/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF May 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Riverdale, Maryland.			22d. LOCATION (City, town, or county) Atlantic City, New Jersey.				
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.					ADDRESS Riverdale, Maryland.		24a. REC'D BY REGISTRAR DATE MAY 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



(M)

(1)

Chemistry

A. G. A.

Miss Bond

Miss Bond: General Bond

Miss Bond: General Bond

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5970 CERTIFICATE OF DEATH 05960											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince Geo.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3401 Bellevue Ave.						d. STREET ADDRESS 3401 Bellevue Ave.					
3. NAME OF DECEASED (Type or print) First ALDEN Middle T. (KEATING) Last KEETING						4. DATE OF DEATH Month May Day 8 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 Nov. 1897		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Yellow Cab Co.				11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Keeting						14. MOTHER'S MAIDEN NAME Alice E. Emily					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW I						16. SOCIAL SECURITY NO. 579-16-9303					
17. INFORMANT Edna Keeting Same as 2						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer to brain 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cancer of left kidney DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 months 20 months										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1st, 1955 to May 1st, 1961, that (I) (we) last saw the deceased alive on May 5th, 1961, and that death occurred at 10:52 PM, from the causes and on the date stated above.											
22a. SIGNATURE Vic Berge Ann						22b. DATE SIGNED May 1st 1961					
22c. PHYSICIAN'S NAME (Type) TIC BERGE ANN						22d. ADDRESS 4317 Gallatin Rd, Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11 May '61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City, town or county) (State) Bladensburg, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home						25a. REC'D BY REGISTRAR MAY 11 '61					
ADDRESS 300-4th St. N.E. Wash. DC						25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

(M)

(I)

Prince George

University

3401 Bellevue Ave.

Albany

Male White

Manager

Charles Manning

Yes W I

University

3401 Bellevue Ave.

(Manning)

Albany

Male White

Relief Co. Co. Secs.

Alice M. Kelly

779-16-9703 and meeting Secs in 8

Notes to be given to Mrs. J.

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The Georgetown

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Washington

August 15 1941

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## CERTIFICATE OF DEATH

Reg. Dist. No.

05961

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>52</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>507 Chillum Road</b>				d. STREET ADDRESS <b>Apt. 301</b> <b>1</b> <b>507 Chillum Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Bayard</b> Middle <b>Cole</b> Last <b>Keough</b>				4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/12/1908</b>	
9. AGE (In years last birthday) yrs. <b>53</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio-Technician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Admiral Sales</b>		11. BIRTHPLACE (State or foreign country) <b>Englewood, New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Frederic William Keough</b>				14. MOTHER'S MAIDEN NAME <b>Ella Cornelius Cole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b> <b>WW II</b>				16. SOCIAL SECURITY NO. <b>577-05-6283</b>			
17. INFORMANT <b>Martha Elizabeth Keough</b>				Address <b>507 Chillum Rd. Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY OBSTRUCTION</b> <b>148X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CANCER TO LUNGS</b> DUE TO (c) <b>FROM CANCER OF PHARYNX</b> INTERVAL BETWEEN ONSET AND DEATH <b>8-12 HOURS</b> <b>3 YEARS</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1953</b> , to <b>1/19</b> , 1954, that I last saw the deceased alive on <b>1/19</b> , 1954, and that death occurred at <b>9A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>905 Sheridan Street, Hyattsville, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Henry R. Wolf</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Henry R. Wolf</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/8/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. - Arlington, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

17

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JAN 15 1912		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
JAN 15 1847		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
JAN 15 1912		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
JAN 15 1847		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		NONE		NONE	

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5972  
MAY 17 1961  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
65962  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Oxon Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7304-Oxon Hill Rd. SE</u>		d. STREET ADDRESS <u>17304-Oxon Hill Rd SE</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET H. Kerby</u>		4. DATE OF DEATH <u>MAY 14 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL S. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Maude Herbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lola J. Stinchcomb</u>		Address <u>5925-Tucker Rd SE WASH 222C</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases</u> DUE TO (c) <u>Coronary Failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 26 1959</u> to <u>5/14/61</u> , 19 <u>61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>5/14/61</u> , 19 <u>61</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edwin G. Lane</u>		22b. DATE SIGNED <u>5/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN G. LANE</u>		22d. ADDRESS <u>5664-Livingston Rd SE Oxon Hill md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-17-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Broadcreek md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Demmons Bros.</u>		25a. REC'D BY REGISTRAR <u>MAY 17 '61</u>	
ADDRESS <u>1661-Good Hope Rd SE WASH 20 SE</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



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James H. Jones

Mr. Jones

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Female White

James H. Jones

James H. Jones

James H. Jones

James H. Jones

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James H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
5973									
65963									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 37 7422 Taylor Street				
c. LENGTH OF STAY IN 1b 1 day					d. STREET ADDRESS 1 Bellemeade				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Alan Kessel					4. DATE OF DEATH May 29 19 61				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 13 April 1961				
9. AGE (In years last birthday) 6 wks.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY unobtainable				
11. BIRTHPLACE (County & State, or foreign country) U.S.A.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frank Robert Kessel					14. MOTHER'S MAIDEN NAME Betty (unobtainable)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none				
17. INFORMANT Hospital Records (same as 1b)					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 754.4 DUE TO (b) Subendocardial Fibroelastosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Congenital Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 4/13/61, 1961, to 5/29/61, that (I) (the) last saw the deceased alive on 5/28/61, 1961, and that death occurred at 12:40 AM from the causes and on the date stated above. 22a. SIGNATURE [Signature] M.D. 22b. DATE SIGNED 5/29/61 22c. PHYSICIAN'S NAME (Type) Dr. Fred Musser., M.D. 22d. ADDRESS Bellemeade., M.D. 23a. BURIAL, CREMATION, REMOVAL (Specify) removal 23b. DATE THEREOF 5/29/61 23c. NAME OF CEMETERY OR CREMATORY Petersburg, W. Virginia 23d. LOCATION (City, town or county) Petersburg, West Va. (State) 24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company 25a. REC'D BY REGISTRAR DATE JUN 1 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines									

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The E. W. Rines Company Washington, D.C., Jan 27  
General E/20/61  
Yerevan, A. V. Rines, Yerevan, USSR

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2/2/61

Can initial heart disease  
Gynecological fibroids  
Conjunctive heart failure

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Hospital records (same as no)

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15 April 1961

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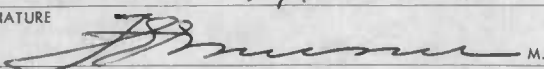
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5974

65964

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> <span style="float: right;">2 Days</span> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">PRINCE GEORGE</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b> d. STREET ADDRESS <b>4115 70th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>Nellie (Nell)</b> <span style="float: right;">W.</span> <b>King</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> <b>16</b> <span style="float: right;">Day</span> Year <b>19 61</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 19, 1896</b>		<b>9. AGE</b> (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>19</b> Hours <b>19</b> Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CLERK-RETIRED</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Gov't</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WEST VIRGINIA</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>RICHARD H. WINGFIELD</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>ADELIA ACKERS</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>						<b>16. SOCIAL SECURITY NO.</b> <b>--</b>						<b>17. INFORMANT</b> <b>Mrs. H.G. WINGFIELD, WAYNESBORO, VA.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____															
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> <b>19</b> <span style="float: right;">p.m.</span>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____				<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5/14</b> , 19 <b>61</b> , <b>to</b> <b>5/16</b> , 19 <b>61</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>5/16</b> , 19 <b>61</b> , <b>and that death occurred at</b> <b>11:00 PM</b> , <b>from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b>  <b>M.D.</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>5/16/61</b>													
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>F. F. MUSSER, M.D.</b>						<b>22d. ADDRESS</b> <b>4410 74 Ave Landover Hills</b>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>23b. DATE THEREOF</b> <b>5/20/1961</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>SALEM CHURCH CEMETERY</b>				<b>23d. LOCATION (City, town or county)</b> <b>WILDWOOD, VA.</b> <span style="float: right;">(State)</span>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Joseph Sawlin's Sons</b>						<b>ADDRESS</b> <b>1756 Pa. Ave. N.W.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>WASH. D.C.</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			
<b>DATE</b> <b>MAY 22 '61</b>						<b>DATE</b> <b>MAY 22 '61</b>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten notes and signatures at the bottom of the page, including a large signature that appears to read "Richard M. Hinkle".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5975											
65965											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 56 W Hyattsville						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 1 7930 15th Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy Kirk					4. DATE OF DEATH May 2 19 61						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 May 1961		9. AGE (In years last birthday) yrs. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles C.					14. MOTHER'S MAIDEN NAME Rosalie Carroll						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 CONGENITAL HEART DISEASE DUE TO (b) (PROBABLY TRANSPOSITION OF GREAT VESSELS) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH LIFE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ATELECTASIA, FOETAL TYPE										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1 MAY 1961, to 2 MAY 1961, that (I) saw the deceased alive on 2 MAY 1961, and that death occurred at 7:10 PM from the causes and on the date stated above.											
22a. SIGNATURE Joseph M. D.					22b. DATE 3 May '61		22c. PHYSICIAN'S NAME (Type)				
22d. ADDRESS 7309 RIGGS RD. HYATTSTVILLE, MD.					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/3/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			23d. LOCATION (City, town or county) (State) Washington D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gosch Sons					ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 4 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kneas		

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Washington D. C.  
May 10, 1900  
General  
Hatchwell, N.Y.  
Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. H. [Signature]  
[Signature]  
[Signature]

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5976

65966

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 20</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP, ANDREWS AFB, MARYLAND</b>				d. STREET ADDRESS <b>307 PARKLAND PLACE SE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>A.</b> Last <b>KNAUSS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>9</b> Year <b>1961</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 NOVEMBER 1958</b>		9. AGE (In years last birthday) <b>2</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>RONALD A KNAUSS</b>				14. MOTHER'S MAIDEN NAME <b>NANCY A MCNUITT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MOTHER</b>		Address <b>SAME AS ITEM #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MEASLES</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9 MAY 1961</b> , to <b>9 MAY 1961</b> , that (I) (we) last saw the deceased alive on <b>9 MAY 1961</b> , and that death occurred at <b>2340</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>John A. Moore</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9 MAY 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A MOORE, MAJOR USAF MC</b>				22d. ADDRESS <b>USAF HOSP, ANDREWS AFB, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>MAY 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VA, VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas M. Hyson</i>				25a. REC'D BY REGISTRAR DATE <b>MAY 12 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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47X-3

CERTIFICATE OF DEATH

2978

(M)

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. DATE OF DEATH: [illegible]  
9. PLACE OF DEATH: [illegible]  
10. SIGNATURE OF REGISTRAR: [illegible]  
11. SIGNATURE OF WITNESS: [illegible]  
12. SIGNATURE OF DECEASED: [illegible]

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4306 Farragut Street</b>					d. STREET ADDRESS <b>4306 Farragut Street</b>									
3. NAME OF DECEASED (Type or print) <b>Harold Julius Kohr</b>					4. DATE OF DEATH <b>May 10, 19 61</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sep. 28, 1903</b>		9. AGE (In years last birthday) <b>57</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <b>William Kohr</b>					14. MOTHER'S MAIDEN NAME <b>Wilhemina Hess</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>1922-25</b>					16. SOCIAL SECURITY NO. <b>220-05-4725</b>					17. INFORMANT <b>33 Bloomsbury Square Annapolis, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b>														
578X DUE TO (b) <b>Gastrointestinal hemorrhage</b>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <b>James I. Boyd</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>May 10th, 1961</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>5-12-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>					
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>					24a. REC'D BY REGISTRAR <b>DATE MAY 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

FOR FILE  
HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
5978 05969													
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <b>Prince George</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 District Heights</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>						d. STREET ADDRESS <b>6510 Marlboro Pike</b>							
3. NAME OF DECEASED (Type or print) <b>Beulah</b>			First <b>BENSON</b> Middle <b>Coontz</b> Last			4. DATE OF DEATH <b>May 27 19 61</b>			Month <b>May</b> Day <b>27</b> Year <b>19 61</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-7-80</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dr. Benj. R. Benson</b>						14. MOTHER'S MAIDEN NAME <b>Mary A. Armacost</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mary K Noland, Daughter</b>				Address <b>Same as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction - rt.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis of the</b> (c) <b>Arteriosclerosis of the</b> cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis of the</b>										INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1, 1953</b> to <b>May 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 27, 1961</b> , and that death occurred at <b>6:15 P</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>William Brainin</b>						M.D. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>						22b. DATE SIGNED <b>5/27/61</b>							
22d. ADDRESS <b>6124 Central Ave, Capitol Hgts Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>				23b. DATE THEREOF <b>5-31-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>				23d. LOCATION (City, town or county) (State) <b>Pikesville 8, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Serv. 622 York Rd Towson</b>						25a. REC'D BY REGISTRAR <b>JUN 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>					

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5979

05970

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> c. LENGTH OF STAY IN 1b <u>14 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7511 Marlow Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> d. STREET ADDRESS <u>7511 Marlow Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ANTHONY</u> Middle <u>KROLAK</u> Last <u>KROLAK</u>		<b>4. DATE OF DEATH</b> Month <u>MAY</u> Day <u>12</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>6-6-1910</u> <b>9. AGE</b> (In years last birthday) <u>50</u> yrs. <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months <u>5</u> Days <u>10</u> Hours <u>30</u> Min. <u>0</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Barber</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Lawrence Krolak</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Josephine Korischa</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>9-13-93094</u> <b>17. INFORMANT</b> <u>Lawrence Krolak, same as #2</u> Address <u>same as #2</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arterio Sclerosis / Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>1952</u> to <u>MAY 12</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MAY 10</u> 19 <u>61</u> , and that death occurred on <u>MAY 12</u> 19 <u>61</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Edward A. Palank</u> M.D.			<b>22b. DATE</b> <u>5-12-61</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>EDWARD A. PALANK</u> <b>22d. ADDRESS</b> <u>5203 S. 16th Hill Rd</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5-16-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington, Va</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Gerald Mattingly</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Wash 3.00</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>23d. LOCATION</b> (City, town, or county) <u>2X Myers, Va</u> (State) _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOPE FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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5980  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05971

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5860 Branch Ave., SE.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland. d. STREET ADDRESS 4921- Eastern Lane S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM First GEORGE Middle LANDON Last		4. DATE OF DEATH May 6th 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 23- 1875
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cedar Hill Cem. Nurseman.		10b. KIND OF BUSINESS OR INDUSTRY 1 Nurseman.	
11. BIRTHPLACE (State or foreign country) Silver Spring, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver A. Landon		14. MOTHER'S MAIDEN NAME Margarite Chaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Leonora B. Landon		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. glomerulonephritis (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 5 yrs 25 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostate Hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/15 1959 to May 6, 1961, that (I) (we) last saw the deceased alive on May 5, 1961, and that death occurred at 11:50 AM from the causes and on the date stated above.			
22a. SIGNATURE Leo H. Mugmon		22b. DATE SIGNED 5/6/61	
22c. PHYSICIAN'S NAME (Type) Leo H. Mugmon		22d. ADDRESS 3109- Nichols Ave., SE. Wash., DC.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 9th 61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		25a. REC'D BY REGISTRAR 18810 Good Hope Rd SE Washington DC DATE MAY 9 '61	
25b. REGISTRAR'S SIGNATURE			



STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 CERTIFICATE OF DEATH

1020



1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of medical examiner: \_\_\_\_\_

12. Signature of registrar: \_\_\_\_\_





1  
FOR STATE  
HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4931 Astor Place S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Joseph Nathaniel Lee</b>			<b>4. DATE OF DEATH</b> <b>May 16, 1961</b>			<b>5. SEX</b> <b>Male</b>			<b>6. COLOR OR RACE</b> <b>Colored</b>		
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>8/29/43</b>			<b>9. AGE</b> (In years last birthday) <b>17 yrs.</b>			<b>IF UNDER 1 YEAR</b> Months <b>17</b> Days <b>16</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Laborer</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington, D.C.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Lofton Henry Lee, Sr.</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Mildred Harps</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b>			<b>17. INFORMANT</b> <b>Lofton Henry Lee</b>			<b>Address</b> <b>4931 Astor Place, S.E.</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epidural Hemorrhage</b> DUE TO (b) <b>Fractured Skull secondary to trauma</b> (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b> <b>3 days</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>Struck on the head during an altercation</b>								
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>Hour 11:51 p.m. 5/13/61</b>			<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Street</b>			<b>20f. (City or town) (County) (State)</b> <b>Fairmont Heights P. G. Md</b>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>5/16/61</b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>22b. DATE THEREOF</b> <b>5-20-61</b>			<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Lincoln Memorial</b>			<b>22d. LOCATION (City, town, or country) (State)</b> <b>Suitland Md.</b>		
<b>23. FUNERAL DIRECTOR</b> <b>Rollins, Myrtle K.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>4339 Hunt Pl. N.E.</b>					
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Hines</b>						<b>DATE</b> <b>MAY 22 '61</b>					

MEDICAL CERTIFICATION

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5982

05973

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>222 9th Street</u>				d. STREET ADDRESS <u>222 9th Street</u>					
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Guy</u> Middle <u>Leishure</u> Last				4. DATE OF DEATH <u>May 15</u> 19 <u>61</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 30 1900</u>			
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lanham, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>									
13. FATHER'S NAME <u>William Leishure</u>				14. MOTHER'S MAIDEN NAME <u>Emma Davidson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-12-1141</u>		17. INFORMANT <u>Mrs Mary E. Leizer, Lanham, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - wandering - met</u> 199X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>none</u>								INTERVAL BETWEEN ONSET AND DEATH <u>9 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY <u>Month, Day, Year</u> Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 16, 1960</u> to <u>May 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>5/15/61</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>N B Steward</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>N B STWARD</u>				22d. ADDRESS <u>314 Compton Landlord</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>May 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ing Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Lanham Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Davidson, Lanham, Md.</u>				25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>			
				DATE <u>MAY 22 '61</u>					

4-13213-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5983

05974

<b>1. PLACE OF DEATH</b> a. COUNTY Prince George MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN b. 8 days		d. STREET ADDRESS 2110 Chapman Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) Della Limle		<b>4. DATE OF DEATH</b> Month May Day 15 Year 1961	
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 9-17-76
<b>9. AGE</b> (In years last birthday) 84 yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) Ohio		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> William Martin		<b>14. MOTHER'S MAIDEN NAME</b> Sarah Ann Smith	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) no		<b>16. SOCIAL SECURITY NO.</b> yes	
<b>17. INFORMANT</b> Paul E. Smithson, Address same as #2			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA, CEREBRAL THROMBOSIS (REMOTE) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. TIME OF INJURY</b> Hour e.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20b. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20c. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 11/15 to 5/15, 1961, that (I) (we) last saw the deceased alive on May 15, 1961 and that death occurred at 2:50 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> E. James Duke		<b>22b. DATE SIGNED</b> 5/16/61	
<b>22c. PHYSICIAN'S NAME</b> (Type or print) E. JAMES DUKE		<b>22d. ADDRESS</b> 6607 RIVERDALE RD, RIVERDALE, MD	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 5-19-61	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> Browns Chapel Cem		<b>23d. LOCATION</b> (City, town or county) (State) Clarksburg, Ohio	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> W. J. Chambers		<b>25a. REC'D BY REGISTRAR</b> DATE MAY 22 '61	
<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Hines			



12

342

DATE: 10/10/2019 TIME: 10:10:10

2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5984

65975

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md/				b. COUNTY Prince George															
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General				d. STREET ADDRESS 6909 D Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) John				First		Middle Robert		Last Maddox SR.		4. DATE OF DEATH May 10 1961													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-96		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Guard, Retired				10b. KIND OF BUSINESS OR INDUSTRY D. C. Transit				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME Robert Leo Maddox				14. MOTHER'S MAIDEN NAME Edith Wink				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. UKN				17. INFORMANT Mildred L. MADDox				Address 6909 D ST. SEAT PLEASANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 5/9 to 5/10, 1961, that (I) (we) last saw the deceased alive on 5-10-1961, and that death occurred at 6:45 A.M. from the causes and on the date stated above.																							
22a. SIGNATURE Max M. Herzberg				M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) Dr. Max M. Herzberg				22d. ADDRESS 7016 Greig Street, Seat Pleasant, Md.																			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 5-13-61				23c. NAME OF CEMETERY OR CREMATORY WASH. NAT'L				23d. LOCATION (City, town or county) (State) SUTLAND Rd. Pr. Geo. Co. MD.											
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.				25a. REC'D BY REGISTRAR DATE MAY 12 '61				25b. REGISTRAR'S SIGNATURE C. Arthur S. Evans															

M

I

John W. Hargrave

## CERTIFICATE OF DEATH

Reg. Dist. No.

05976

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASHINGTON D.C.</b> b. COUNTY <b>47X-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESTVILLE</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8407 - PUMPHREY DRIVE</b>				d. STREET ADDRESS <b>1005-4TH ST. N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>T.</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>5</b> - Day <b>10</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1878</b> <b>6-3-1878</b>	
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL LISTON</b>				14. MOTHER'S MAIDEN NAME <b>ANN KING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		INFORMANT <b>FRED MARTIN</b>		Address <b>ITEM</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral-vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Suppurative Parotitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-2</b> , 19 <b>61</b> , to <b>5-10</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/9</b> , 19 <b>61</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6480 N. H. Ave. TAKOMA PARK Md.</b> DATE SIGNED <b>5/10/61</b>							
ACTUAL SIGNATURE <b>R.C. Kirchner</b>		M.D. <b>6480 N. H. Ave. TAKOMA PARK Md.</b>					
PHYSICIAN'S NAME (Type) <b>R.C. KIRCHNER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-13-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		22d. LOCATION (City, town, or county) (State) <b>WASH. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Hanlon - 3831 GA. AVENUE</b>				24. REC'D BY REGISTRAR <b>MAY 17 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. S. Thayer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland  
County of Prince George  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 19th day of April, 1914, at the residence of the deceased, I examined the body of  
Name of Deceased  
and found that death had taken place from  
Cause of Death  
at the age of  
years.

Witness my hand and the seal of my office this 19th day of April, 1914.  
Signature of Physician  
J. C. [Signature]  
J. C. [Signature]  
J. C. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5986

05977

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 214 C. St., N. W.	
3. NAME OF DECEASED (Type or print) First Alonzo Middle - Last Mason		4. DATE OF DEATH Month 5 Day 21 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/17
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Berry Mason		14. MOTHER'S MAIDEN NAME Frances Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postoperative death. Bronchial obstruction with atelectasis. DUE TO (b) Left anterior stage thoracoplasty DUE TO (c) Pulmonary tuberculosis, far advanced, active (2 yrs., 5 mos.,) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 30 minutes 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/21 to 8:15 to 5/21, 1961, that (I) (we) last saw the deceased alive on 5/21 1961, and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 5/21/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-61	
23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City, town or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Johnson + Jenkins		25a. REC'D BY REGISTRAR DATE MAY 25 '61	
ADDRESS 4804 Balboa NW		25b. REGISTRAR'S SIGNATURE Anthony S. Kraus	

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11-25-61

Johnson + Johnson 4804 Baltimore



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FOR STATE  
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b 4 1/2 mo					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Clarence Howard Mason					4. DATE OF DEATH May 26 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1909		9. AGE (In years last birthday) 51 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy equipment operator		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Charles Lincoln Mason					14. MOTHER'S MAIDEN NAME Pearl Thomas					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 379-05-0625					
17. INFORMANT Mrs E.C. Powell, Woodlawn, Maryland					6829 Buchanan Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary embolism										
DUE TO (b) Surgery for pyloric obstruction										
DUE TO (c) Second and third degree burns of lower extremities										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) fire Was handling some gasoline that got on clothes and caught on					
20c. TIME OF INJURY Month, Day, Year 5:45 a.m. 1/ 13 19 61			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Berwyn Prince George's Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED May 26, 1961					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 5/31/61		22c. NAME OF CEMETERY OR CREMATORY Simon		22d. LOCATION (City, town, or country) (State) W.Va.	
23. FUNERAL DIRECTOR W.W. Chambers Co					ADDRESS 1400 Chapin St N.W.		24a. REC'D BY REGISTRAR DATE MAY 29 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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NO. 101  
JULY 1951

UNITED STATES DEPARTMENT OF HEALTH  
MEDICAL EXAMINER, STATE OF TEXAS

Office of the Medical Examiner

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

Prison Hospital

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Prison Hospital

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5988

65979

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8801 48th avenue</b>				d. STREET ADDRESS <b>8801 48th avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Maxwell</b> Last <b>Maxwell</b>				4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>19 61</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 19, 1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John Petrie</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Criuchant</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Elizabeth Fleet</b>				Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>15 hr</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>5/7 1961</b> to <b>5/19 1961</b> , that (I) (we) last saw the deceased alive on <b>5/10 1961</b> , and that death occurred at <b>11:48 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr C D Connor</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr C D Connor</b>				22d. ADDRESS <b>4317 Berwyn Road College Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 13, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Beltville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

CERTIFICATE OF DEATH

1969

M

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Date of birth: [illegible]  
4. Place of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05980

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>Dead on arrival</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills</b>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Harold</b> Last <b>McLaren</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10th.</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28th. 1906</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>5 &amp; 10 ¢ Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John David McLaren</b>		14. MOTHER'S MAIDEN NAME <b>Elinore Allen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-7999</b>	
17. INFORMANT <b>Mrs Annie Mae McLaren, same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary artery disease</b> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>May 10th., 1961</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		DATE <b>MAY 15 '61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>W. W. Chambers Co. 517 11th St. SE Wash., DC</b>			
24a. REC'D BY REGISTRAR <b>Arthur S. Harris</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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05981

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN 1b <b>3 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOME</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRENTWOOD</b>			
f. STREET ADDRESS <b>3704 QUINCY STREET</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>M.</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>5</b> Day <b>1</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 9, 1872</b>	
9. AGE (In years last birthday) <b>89 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED U.S. GOVT.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN W. MILLER</b>				14. MOTHER'S MAIDEN NAME <b>ANNA LUBER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>SACRED HEART HOME</b>				Address <b>HYATTS. MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>26 months</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/4/1959</b> to <b>5/1/1961</b> , that (I) <del>(the)</del> last saw the deceased alive on <b>May 1, 1961</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas F. Collins M.D.</b> M.D.				22b. DATE <b>May 2, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Collins, M.D.</b>				22d. ADDRESS <b>322-H. St. N.E. - Washington 2, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				25a. REC'D BY REGISTRAR <b>MAY 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiser</b>	

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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W/1961

May 2, 1961

Thomas P. Collins, M.D.

FRANCIS G. COLLINS, M.D.

John J. Kinn

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
5992 CERTIFICATE OF DEATH 05982												
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Muirkirk d. STREET ADDRESS Bacon Lane - Apt. #9 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ruth Costello Pearson			4. DATE OF DEATH May 5 19 61			5. SEX Female			6. COLOR OR RACE Colored			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH March 29, 1923			9. AGE (In years last birthday) 38 yrs.			IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Forquier Col - Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mose Johnson						14. MOTHER'S MAIDEN NAME Rosetta Davis						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Raymond Pearson - Husband - Same Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO hypertension (b) DUE TO (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obese wt 335. INTERVAL BETWEEN ONSET AND DEATH 4 hours 3 yrs												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.												
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												
20f. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from May 4, 1961, to May 5, 1961, that (I) (we) last saw the deceased alive on May 5, 1961, and that death occurred at 1:38A from the causes and on the date stated above.												
22a. SIGNATURE L W Malin M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5-5-61												
22c. PHYSICIAN'S NAME (Type) L. W. Malin, M. D. 22d. ADDRESS 4404 Queensbury Road, Riverdale, Maryland												
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 5-8-61 23c. NAME OF CEMETERY OR CREMATORY Queens Chapel 23d. LOCATION (City, town or county) (State) Muirkirk, Md.												
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. Anderson ADDRESS Rockville, Md. 25a. REC'D BY REGISTRAR DATE MAY 10 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus												









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ARMED AIR FORCE BASE

USAF HOSP, ANDREWS AFB, MARYLAND

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CAUTION

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288-22-0122 PERSONNEL RECORDS

*up to 1000*

THOMAS E. WENTURA, Capt USAF MC USAF HOSP ANDREWS AFB, MARYLAND

MAY 28 61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
5994													
CERTIFICATE OF DEATH													
65984													
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beland Memorial Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Stafford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Staff Gate</u> d. STREET ADDRESS <u>83X-3</u>							
3. NAME OF DECEASED (Type or print) <u>Sidney Oscar Percy</u> First Middle Last						4. DATE OF DEATH <u>May 23</u> 19 <u>61</u> Month Day Year							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 24 1899</u>		9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Caldwell N. Carolina USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>Quenzo Whitehead Percy</u>						14. MOTHER'S MAIDEN NAME <u>Mary L. Brasswell</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>227-05-0150</u>							
17. INFORMANT <u>Ray Donald Percy, Son, Md</u>						Address <u>  </u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>General Varmer</u> (b) <u>General Arthur Jones</u> (c) <u>Post-operative stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>  </u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from <u>May 15 1961</u> to <u>May 23 1961</u> , that (I) <u>no</u> saw the deceased alive on <u>May 15 1961</u> and that death occurred at <u>245A</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert C Wingfield</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C WINGFIELD</u>						22b. DATE SIGNED <u>May 23 1961</u>							
22d. ADDRESS <u>Laurel, Md</u>						22e. ADDRESS <u>329 Prince George St</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/26/61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Central Church Cemetery Clifton Forge Va.</u>			23d. LOCATION (City, town or county) (State) <u>  </u> <u>  </u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson</u>						ADDRESS <u>Laurel, Md</u>		25a. REC'D BY REGISTRAR <u>61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			
DATE <u>MAY 29 '61</u>						DATE <u>MAY 29 '61</u>							

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*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Robert" and "Christie" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5995

05985

1. PLACE OF DEATH a. COUNTY <u>Prince George's Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George's Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Ln, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown, Maryland</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>6970 Allentown Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alfred M. Purdy</u>		First Middle Last		4. DATE OF DEATH <u>May 7 1961</u>		Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-07</u>		9. AGE (In years, last birthday) <u>53</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist RETIRED, NAVAL MAGAZINE PHOTOGRAPHY</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver E. Purdy</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL DOW</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CARRIE A. Purdy</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u> 199X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Adeno Ca Stomach</u> (a), stating the underlying cause last. DUE TO (c) <u>Adeno Ca Rectum</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-23-60</u> , to <u>5-7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> , 19 <u>61</u> , and that death occurred at <u>9:20 A</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Jeannette C. Bateman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-7-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JEANNETTE C. BATEMAN</u>				22d. ADDRESS <u>940-25th St. NW Wash D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATL. CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS</u>				ADDRESS <u>1601 GOOD HOPE RD WASH. 20-D.C.</u>		25. REGISTRAR'S SIGNATURE <u>Clairmont E. Kinn</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5996

05986

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Hillside</b> d. STREET ADDRESS <b>1223 53rd Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Sylvester (N.M.N.) Ramsey</b>			4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-96</b>		9. AGE (In years last birthday) <b>64 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscape Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-16-8877A</b>		17. INFORMANT <b>Ruth E. Ramsey, 1223--53rd Ave., Hillside, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <b>4 Hr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 4</b> , 19 <b>61</b> to <b>May 7</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>May 7</b> , 19 <b>61</b> and that death occurred at <b>11 A.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>George Hageage</b>		22b. DATE SIGNED <b>5-7-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Geo. Hageage, M.D.</b>	
22d. ADDRESS <b>3717 38th Ave. Cottage City, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/10/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
23d. LOCATION (City, town or county) <b>Washington, D.C.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers &amp; Co. 517 11th St. S.E.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. L. &amp; K. K.</b>	

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# 1 FOR STATE HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5997											
05987											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 44 Cottage City					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 14006 Parkwood Street					
3. NAME OF DECEASED (Type or print) John F Reagan						4. DATE OF DEATH May 14 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1887		9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Virginia Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME Michael Joseph Reagan						14. MOTHER'S MAIDEN NAME Ida Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W. W. I.						16. SOCIAL SECURITY NO. 17. INFORMANT William E. Bruce 6111 Forest Road Cheverly, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 Parkinsons Disease, arteriosclerosis advanced											
DUE TO (b) Fracture of the neck of the right femur											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell going to bath room					
20c. TIME OF INJURY Month, Day, Year 4 Hour a.m. 3/8/61			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) Cottage City (County) P. G. (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED 5/14/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 5/17/61			22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		
						22d. LOCATION (City, town, or country) Colmar Manor, Md.					
23. FUNERAL DIRECTOR Nalley's Funeral Home, Inc.						24a. REC'D BY REGISTRAR DATE MAY 18 '61			24b. REGISTRAR'S SIGNATURE Arthur S. Hume		

(M)

(1)

1. Michael Joseph Reegan later Reegan  
for W.M.A.

111 1st Ave. Room  
New York, N.Y.

Michael Reegan, deceased, born January  
1, 1900, at New York, N.Y.

Will copy to each room

Covered by 1. 1. 1.

2/11/51

2/11/51

2/11/51  
Michael Reegan  
111 1st Ave. Room  
New York, N.Y.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 23 Film G288 6/13/61

5998

05988

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>1 HR 9 MIN</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP, ANDREWS AFB, MD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>19 SUITLAND</b> d. STREET ADDRESS <b>4208 SILVER HILL ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>ANN</b> Last <b>RECTOR</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 MAY 1961</b>
9. AGE (In years lost birthday) <b>— yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>9</b>	11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>WILLIAM LOUIS RECTOR</b>		14. MOTHER'S MAIDEN NAME <b>ROSE ANN DEAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>FATHER</b>		Address <b>SAME AS ITEM #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IRREVERSIBLE HYPOXIA</b> <b>773.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 HR 9 MIN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>31 May 1961</b> to <b>31 May 1961</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>31 May 1961</b> , and that death occurred at <b>1150p</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John D Blackburn</b> M.D.		22b. DATE SIGNED <b>1 June 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D BLACKBURN, Capt USAF MC</b>		22d. ADDRESS <b>USAF HOSP, ANDREWS AFB, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF _____	
23c. NAME OF CEMETERY OR CREMATORY <b>Morgue District of Columbia</b>		23d. LOCATION (City, town, or county) <b>19 &amp; E St., SE, Wash., D. C.</b> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE _____		25a. REC'D BY REGISTRAR _____	
ADDRESS _____		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Funes</b>	
DATE <b>JUN 6 '61</b>			

2251213 XV4





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1730





## CERTIFICATE OF DEATH

Reg. Dist. No.

05989

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltoville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivendale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>THE 11 Cedar Rest Home</u>		d. STREET ADDRESS <u>4501 Oliver St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIZZIE CATHERINE RESH</u>		4. DATE OF DEATH Month Day Year <u>MAY 24, 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 17, 1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>YORK CO. PENN'A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM ALLISON</u>		14. MOTHER'S MAIDEN NAME <u>MARY RAVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>NAOMI HOUDESHEL</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>20 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 20, 1955</u> , to <u>May 24, 1961</u> , that I last saw the deceased alive on <u>May 24, 1961</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. D. Baker M.D.</u>		ADDRESS (Street, city or town, state) <u>2513 Buck Lodge Rd</u> DATE SIGNED <u>5-24-61</u>	
PHYSICIAN'S NAME (Type) <u>R. D. BAKER, M.D.</u>		<u>Philphi Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/27/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Rivendale, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 29 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. RACE		4. AGE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		W		39		12-1-35		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
ATTORNEY		HEART DISEASE		NATURAL		HYPERTENSION		CORONARY THROMBOSIS		MEDICAL		AUTOPSY		J. H. [Signature]	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF BURIAL OFFICIAL		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CHURCH	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICIALS IN THE CITY OR COUNTY WHERE THE DECEASED RESIDES.

10-1-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6000

65990

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>R.F.D. Box 4150</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>		4. DATE OF DEATH <b>May 8 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1961</b>
9. AGE (In years last birthday) <b>1 3 15</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Ross</b>	
14. MOTHER'S MAIDEN NAME <b>Hilda Johnson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO (b) <b>Sepsis neonatorum</b> DUE TO (c) <b>Sepsis neonatorum</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 7, 1961</b> , to <b>May 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 8, 1961</b> , and that death occurred at <b>6:45P</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas A. Christensen</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen</b>		22b. DATE SIGNED <b>5/9/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>College Park, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-11-61</b>		23b. DATE THEREOF <b>5-11-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Ch. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Upper Marlboro Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nancy Washington</b> ADDRESS <b>4425 Deane Ave NE</b>		25. REC'D BY REGISTRAR DATE <b>MAY 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

VR A15 (4)  
15M 9/60

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TO HOSTEL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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6001  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
CERTIFICATE OF DEATH  
05991

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MAYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>NEW YORK</b> b. COUNTY <b>WESTCHESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>AVONDALE</b>		c. LENGTH OF STAY IN lb <b>5-MOS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW ROCHELLE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2301 QUEENS CHAPEL RD.</b>				d. STREET ADDRESS <b>32 ROBINS CRESCENT</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>JAMES</b> Last <b>SCHAEFER</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 28 1931</b>	
9. AGE (In years lost birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VICE PRES. SCHAEFER, Inc. Stamford Conn.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Stamford Conn.</b>		11. BIRTHPLACE (State or foreign country) <b>CONN.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM J. SCHAEFER</b>				14. MOTHER'S MAIDEN NAME <b>IRMA WENNING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>unobtainable</b>			
17. INFORMANT <b>SHIRLEY M. SCHAEFER</b>				Address <b>2301 QUEENS CHAPEL RD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>199X</b> (c) <b>8 mos</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 5/15</b> 19 <b>61</b> , to <b>5/16</b> 19 <b>61</b> , that (I) <b>(w)</b> last saw the deceased alive on <b>5/15</b> 19 <b>61</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>William L. Howell</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William L. Howell</b>				22d. ADDRESS <b>Wash Clinic, Wash 15 DC.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/18/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>				ADDRESS <b>Washington, D. C.</b>		25a. REG'D BY REGISTRAR <b>MAY 17 61</b>	
				25b. REGISTRAR'S SIGNATURE <b>William L. Howell</b>			

1000

(M)

NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

1. Name of deceased  
2. Age  
3. Sex  
4. Date of birth  
5. Place of birth  
6. Date of death  
7. Place of death  
8. Cause of death  
9. Manner of death  
10. Occupation  
11. Education  
12. Religion  
13. Marriage  
14. Single  
15. Married  
16. Widowed  
17. Divorced  
18. Remarks



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 6002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65992

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
c. LENGTH OF STAY IN 1b <b>D. O. 2</b>		d. STREET ADDRESS <b>Harrison</b> <b>761 South <del>XXXXX</del> Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Allen</b> Last <b>Shackelford</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 8, 1916</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>45</b> Days <b>45</b>	IF UNDER 24 HRS. Hours <b>45</b> Min. <b>45</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Shackelford</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-12-1432</b>	
17. INFORMANT <b>Mrs Abbott Shackelford, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>9.12.5</b> DUE TO <b>CRUSHING INJURY of Pelvis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CRUSHING INJURY of Pelvis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Was operating a loading machine that turned over</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>1:00</b> p.m. <b>5/9/61</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Oxon Hill P. G. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5/9/61</b> DATE SIGNED	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 12, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>	22d. LOCATION (City, town, or country) (State) <b>Falls Church, Va.</b>
23. FUNERAL DIRECTOR <b>R. J. Murphy</b>		24a. REC'D BY REGISTRAR <b>524 Columbia Pike, Arlington, Va.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>MAY 15 '61</b>	

14



Q:

9:5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
6003													
05993													
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGE'S GENERAL</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PG</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITAL HEIGHTS</u> d. STREET ADDRESS <u>413 50th AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>TERRI LEE SIMPSON</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1961</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 17, 1961</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>PRINCE GEO.'S Co, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WALTER SIMPSON</u>						14. MOTHER'S MAIDEN NAME <u>PUGH</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tetralogy of Fallot</u> 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Congenital Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												INTERVAL BETWEEN ONSET AND DEATH <u>since birth</u>  <u>since birth</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from....., 19..... to <u>MAY 25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MAY 25</u> , 19 <u>61</u> , and that death occurred at <u>10:40</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Sidney W. Lowry M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>DR. SIDNEY LOWRY</u>						22d. ADDRESS <u>7200 MARBODD PIKE SE. WASH, DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>BURIAL</u>		<u>5/27/61</u>		<u>oak lawn</u>		<u>BALTO. CO., Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Brooks Bradley Inc.</u>						ADDRESS <u>Dundalk</u>		25a. REC'D BY REGISTRAR <u>22</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>			
DATE <u>MAY 31 '61</u>													

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Page 5. 44b

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**MEDICAL EXAMINER:** The certificate, when forwarded to the DIRECTOR: Passed agent, prior to

O DUTY M  
 please execute  
 4 should be for  
 O FUNERAL  
 or its designate

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE		Maryland b. COUNTY		Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Cheverly		7 days		66 Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince George's General Hospital				1 6009 Longfellow Street					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year			
Marie Lavina Skeen s				May 23 1961					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
Female		White				September 2, 1923 37 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own home		Florida		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John Calhoun		Hx Lavinia Williams							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address					
				James T Skeens , same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hemorrhage and shock + PULMONARY EMBOLISM 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Contused and ruptured pancreas, fracture of 7th and 8th ribs-left (c)		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Driver of an automobile that struck a fixed object							
20c. TIME OF INJURY Month, Day, Year Hour <del>XX</del> 5/ 16 1961 11:36 m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore Baltimore Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/23/61	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D.		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL SPECIES Burial		22b. DATE THEREOF May 26, 1961		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



8006

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1

W. J. Smith, 1001 W. Lincoln Street, Chicago, Ill.

Chicago, Ill., May 20, 1901

Dear Sir:

1001

W. J. Smith, 1001 W. Lincoln Street, Chicago, Ill.

W. J. Smith, 1001 W. Lincoln Street, Chicago, Ill.

1001

W. J. Smith, 1001 W. Lincoln Street, Chicago, Ill.

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W. J. Smith, 1001 W. Lincoln Street, Chicago, Ill.







# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6006

05996

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b> d. STREET ADDRESS <b>1925 Laguna Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>JANIE FRANCES SMITH</b>				<b>4. DATE OF DEATH</b> Month <b>5</b> Day <b>2</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4/14/1899</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Basil Fewell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Hattie Fewell</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Carter Smith</b> Address <b>1925 Leguna Rd</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> (b) <b>Hypertensive Vascular Disease</b> (c) <b>33X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 60</b> <b>to</b> <b>May 61</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>5-2-61</b> , <b>and that death occurred at</b> <b>7:30 PM</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Bernard A. Fitzgerald</b> M.D.				<b>22b. DATE SIGNED</b> <b>5-2-61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Bernard A. Fitzgerald</b>				<b>22d. ADDRESS</b> <b>217 University Blvd E, SS. Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5/5/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill</b>		<b>23d. LOCATION</b> (City, town or county) <b>Suitland</b> (State) <b>Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lee Laurel Home - 300 4th St E</b>				<b>25a. REC'D BY REGISTRAR</b> <b>D.C.</b> <b>DATE</b> <b>MAY 5 '61</b>			
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Basel Revell

Home life

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Bernard A. Stetsch

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

1  
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6007 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65997

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>4 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> d. STREET ADDRESS <b>5949 Ritchie Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Patricia</b> Middle <b>Ann</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1918</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Joe Freeman</b>				14. MOTHER'S MAIDEN NAME <b>Claudine Berger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-24-8261</b>		17. INFORMANT Address <b>Claude W. Smith, same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO 331X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Subdural Hematoma (right side), massive</b> DUE TO (c) <b>hours</b>							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type)				M.D. <b>James I. Boyd</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5/21/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 24-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or country) (State) <b>Southard Maryland</b>	
23. FUNERAL DIRECTOR <b>Senner Bros, 1661-94 Hope Rd, SE</b>				24a. REC'D BY REGISTRAR <b>MAY 23 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Temple Hills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Temple Hills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>15093 Temple Hills Rd.</b>		e. STREET ADDRESS <b>15093 Temple Hills Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>B.</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1871</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>89 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis B. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Marrietta Reid</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Hazel W. Winkelman (Same AS #2 D)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL INSUFFICIENCY</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>CONGESTIVE HEART FAILURE</b> (c) <b>ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>MAY 7</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>MAY 7</b> , 19 <b>61</b> , and that death occurred at <b>8 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. Tribadeau</b>		22b. DATE SIGNED <b>MAY 7, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. Tribadeau</b>		22d. ADDRESS <b>3112 - Alca Ave S E.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/10/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee</b>		25a. REC'D BY REGISTRAR <b>MAY 10 '61</b>	
ADDRESS <b>-300-4th N.E. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HO...  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

Prince George

Temple Hills

2003 Temple Hills Rd.

White & White

West. Hilltop

W. Hilltop

No.

Temple Hills

2003 Temple Hills Rd.

July 2, 1981

W. Hilltop

W. Hilltop

W. Hilltop (same as W. Hilltop)

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05999

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DIST. OF COL.</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN 1b <b>—</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>M.</b> Last <b>SPEER</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 4, 1875</b>	
9. AGE (In years lost birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED - REDCROSS STAFF -</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>— — MC WILLIAM</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>579-44-4003</b>		17. INFORMANT Address <b>MRS. SARA MILLER 11-FORDALL ROAD, N.Y.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 154X DUE TO (b) <b>Metastatic Carcinoma of lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>Carcinoma of Rectum</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>3 years</b> <b>6 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1929</b> to <b>9 May</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8 May</b> 19 <b>61</b> , and that death occurred at <b>645A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Maurice A. Selinger</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9 May 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>MAURICE A. SELINGER</b>				22d. ADDRESS <b>1150 CONNECTICUT AVE. N.W. WASH. DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-12-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Guadagnoli, Inc. 1756 Pa. Ave. NW.</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 12 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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RESEARCH AND ANALYSIS

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6010

06000

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Prince Georges</span> <span style="margin-left: 100px;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Glenn Dale (rural)</span> c. LENGTH OF STAY IN 1b <span style="margin-left: 100px;">26 days</span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="margin-left: 100px;">Glenn Dale Hospital</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <span style="margin-left: 100px;">D. C.</span> <span style="margin-left: 100px;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Washington</span> d. STREET ADDRESS <span style="margin-left: 100px;">1509 North Capitol St.</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="margin-left: 100px;">John</span> <span style="margin-left: 100px;">Stewart</span>			<b>4. DATE OF DEATH</b> Day <span style="margin-left: 100px;">5</span> Month <span style="margin-left: 100px;">17</span> Year <span style="margin-left: 100px;">19 61</span>				
<b>5. SEX</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		<b>6. COLOR OR RACE</b> Negro <input checked="" type="checkbox"/> White <input type="checkbox"/>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Market work		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Union Terminal Market		<b>8. DATE OF BIRTH</b> 11/24/05			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) Va.		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA					
<b>13. FATHER'S NAME</b> Charles Stewart			<b>14. MOTHER'S MAIDEN NAME</b> Polly Howard				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) Unknown		<b>16. SOCIAL SECURITY NO.</b> 578-01-4910		<b>17. INFORMANT</b> Decedent			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 100px;">Bronchogenic carcinoma, left lung, with widespread generalized metastasis</span> DUE TO (b) <span style="margin-left: 100px;"></span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <span style="margin-left: 100px;"></span> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="margin-left: 100px;">Bronchopneumonia, left lung</span>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> 3 months		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <span style="margin-left: 100px;">19</span> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <span style="margin-left: 100px;">4/21</span> <span style="margin-left: 100px;">10.55</span> <span style="margin-left: 100px;">to</span> <span style="margin-left: 100px;">5/17</span> <span style="margin-left: 100px;">1961</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="margin-left: 100px;">5/17</span> <span style="margin-left: 100px;">1961</span> , <b>and that death occurred at</b> <span style="margin-left: 100px;">A.M.</span> <span style="margin-left: 100px;">from the causes and on the date stated above. </span>							
<b>22a. SIGNATURE</b> <span style="margin-left: 100px;">Moe Weiss</span>			<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> 5/17/1961		
<b>22c. PHYSICIAN'S NAME (Type)</b> Moe Weiss, M. D.			<b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.				
<b>23a. BURIAL</b> <input checked="" type="checkbox"/> <b>CREMATION</b> <input type="checkbox"/> (Specify)		<b>23b. DATE THEREOF</b> 5/22/61		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Harmony Memorial Park, Md.			
<b>23d. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="margin-left: 100px;">Robert G. Mason</span>		<b>ADDRESS</b> 2500 Nichols Way, S.E.		<b>23e. REGISTRAR'S SIGNATURE</b> <span style="margin-left: 100px;">Arthur S. Kraus</span>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
06001									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 2442 Iverson Street				
3. NAME OF DECEASED (Type or print) Betty Berneal Stillwagon					4. DATE OF DEATH May 1, 1961				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH October 11, 1917				
9. AGE (In years last birthday) 43					IF UNDER 1 YEAR Months Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY At Home				
11. BIRTHPLACE (State or foreign country) Fayette County, Penn.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Jewell R. McCombs					14. MOTHER'S MAIDEN NAME Benson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Mr. William K. Stillwagon, Hillcrest Hgts., Md.					Address 2442 Iverson St.,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INCREASED INTRACRANIAL PRESSURE 223X DUE TO Conditions, if any, which gave rise to immediate cause (b) HEMORRHAGIC NECROSIS of BRAIN TUMOR (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED May 1, 1961				
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF May 5, 1961				
22c. NAME OF CEMETERY OR CREMATORY CONNELLSVILLE					22d. LOCATION (City, town, or country) (State) Connelville, Fayette Cty., Pa.				
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,					ADDRESS Riverdale, Maryland.				
24a. REC'D BY REGISTRAR DATE MAY 3 '61					24b. REGISTRAR'S SIGNATURE Arthur L. Kraus				



1  
FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6012

06002

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			
c. LENGTH OF STAY IN 1b Dead on arrival				d. STREET ADDRESS 3104 - 63rd., Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) J. Arnold		4. DATE OF DEATH May 17th, 1961		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 8th, 1917		9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arnold J. Stuckley		14. MOTHER'S MAIDEN NAME Grace Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Dorathy Stuckely, same as # 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock		823X		DUE TO (b) Fracture of the base of the skull		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off the road and overturned					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:50 xpm 5/17/61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) Largo (County) P. G. (State) Md/	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 17th., 1961	
ACTUAL SIGNATURE James I. Boyd		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-1961	
22c. NAME OF CEMETERY OR CREMATORY Grand View Cem -		22d. LOCATION (City, town, or county) Allentown, Penna		23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		24a. REC'D BY REGISTRAR MAY 22 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hays							

MEDICAL CERTIFICATION

THE STATE  
OF NEW YORK

(M)

1915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1915

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1915	
Place of Birth		Place of Death		Cause of Death		Manner of Death	
New York City		New York City		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses	
Teacher		High School		Married		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Remarks	
Jan 15, 1915		10:00 AM		New York City		[Remarks]	

TO: **LEGAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

6013

06003

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>12 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>3308 Stanford Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mark W Thomas</b>				4. DATE OF DEATH <b>May 27 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>55 yrs.</b>	
9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant Administrative U. S. Government Office</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kansas</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U S A</b>	
13. FATHER'S NAME <b>Willard Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Dodge</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Grace Thomas</b>			
17. INFORMANT <b>Hyattsville, Md.</b>				Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE (RT. VENTRICLE)</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>26 May 1961</b> , to <b>27 May 1961</b> , that (I) <del>two</del> last saw the deceased alive on <b>27 May 1961</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon L. Gallin</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 27-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon L. Gallin</b>				22d. ADDRESS <b>7206 Colesville Road, W. Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 30, 1961</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Immanuel Methodist</b>		23d. LOCATION (City, town or county) (State) <b>Horsehead Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 31 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6014		Items 11, 12, 13 & 14 Film 6289 6/23/61		06004	
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Charles County			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Malcom Malcolm	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter R. Thompson		4. DATE OF DEATH Month Day Year May 28 19 61			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-96	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia U.S.A.	
13. FATHER'S NAME unknown Thompson		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 28, 1961, to May 28, 1961, that (I) (we) last saw the deceased alive on May 28, 1961, and that death occurred at 1.25 P.M. on the causes and on the date stated above.					
22a. SIGNATURE Max M. Herzberg		M.D.		22b. DATE SIGNED 5/29/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 7016 Craig St. East Phoenix, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/61		23c. NAME OF CEMETERY OR CREMATORY Hill Top	
23d. LOCATION (City, town or county) Hill Top		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Capital		ADDRESS 719 Kennedy		25a. REC'D BY REGISTRAR DATE JUN 1 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

(M)

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Capital

Hill Top

Hill Top

TO HOSE OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with  
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VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6015

06005

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>		c. LENGTH OF STAY IN 1b <b>2- Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights, Maryland</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5107- 25th Avenue S. E.</b>	
d. STREET ADDRESS <b>5107- 25th Avenue S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CASPER</b> Middle <b>J.</b> Last <b>TINKELBERG</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15th</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3- 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV.</b>	
11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Tinkelenberg</b>		14. MOTHER'S MAIDEN NAME <b>Nellie De Vries</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. # 1.</b>	
17. INFORMANT <b>Mrs. Gertrude O'Neill Tinkelenberg</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Arteriosclerosis, etc.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 min</b> <b>10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 19 53</b> to <b>MAY 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>MAY 15 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Leo H. MUGMON</b>		22b. DATE SIGNED <b>5/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO H. MUGMON M.D.</b>		22d. ADDRESS <b>2711 GAITHER ST. SE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 18- 61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Brothers</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. K...</b>			

1915

CERTIFICATE OF DEATH

1915



CHIEF CLERK

1  
FOR STATE  
HEALTH DEPT.  
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6016

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville d. STREET ADDRESS Route # 2, Box 48 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Edward Tippet Jr.		4. DATE OF DEATH Month Day Year May 25, 19 61					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1959	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence Edward Tippet Sr.				14. MOTHER'S MAIDEN NAME Joan Ellen Mullikin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Clarence Edward Tippet Sr, Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRACHEOBRONCHITIS 501X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) SEVERE CEREBRAL EDEMA						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/25/61 Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Oak Cemetery		22d. LOCATION (City, town, or country) (State) Mitchellville Md.	
23. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Fun'l Home-Upper Marlboro, Md.				24a. REC'D BY REGISTRAR JUN 1 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

Form with multiple sections, including fields for name, address, and other personal information. The text is mirrored and appears to be a scan of a document with bleed-through or a double-sided print. Key sections include:

- Top section: Fields for name, address, and contact information.
- Middle section: Fields for date of birth, sex, and other personal details.
- Bottom section: Fields for occupation, education, and other background information.

The form is filled out with handwritten or typed text, which is difficult to read due to the mirroring and low quality of the scan. Some legible text includes "U.S.A." and "John".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6017											
07146											
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 Hr 20 Min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b> d. STREET ADDRESS <b>X</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>			4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 61</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>Colored</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>X</b>			8. DATE OF BIRTH <b>May 26, 1961</b>			9. AGE (In years last birthday) <b>5</b> yrs.			IF UNDER 1 YEAR Months <b>5</b> Days <b>20</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Chester Townsend</b>						14. MOTHER'S MAIDEN NAME <b>Anna Jean Burroughs</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mother</b>			Address <b>Same</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia (Bull at 14 yrs)</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Atelectasis</b> (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 26, 1961</b> to <b>May 26, 1961</b> that (I) (we) last saw the deceased alive on <b>May 26, 1961</b> and that death occurred at <b>8:50 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas A. Christensen</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>5/29/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr Thomas Christensen M.D.</b>						22d. ADDRESS <b>6905 Baltimore Ave., College Park, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE THEREOF <b>6-21-61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>			23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. P. Jr., Administrator</b>						25a. REC'D BY REGISTRAR <b>JUN 22 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>		

07116

OFFICE OF THE SECRETARY OF DEFENSE

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06007

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>			d. STREET ADDRESS <u>Glenarden</u> <u>6th and Lincoln Avenue</u>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Nathaniel</u> Last <u>Tucker</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 61</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1960</u>		9. AGE (in years last birthday) yrs. <u>9</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Robert Harris</u>		
14. MOTHER'S MAIDEN NAME <u>Barbara Tucker</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Barbara Tucker, same as # 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Compression between mattress and foot of bed</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Baby rolled off end of bed between mattress and foot</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Noon</u> p.m. <u>5/ 20</u> 19 <u>61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Glenarden</u>	(County) <u>P. G.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>			DATE SIGNED <u>5/20/61</u>		
EXAMINER'S NAME (Type) <u>James I. Boyd</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-25-61</u>			22b. DATE THEREOF <u>5-25-61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem.</u>			22d. LOCATION (City, town, or country) (State) <u>Switland Md.</u>		
23. FUNERAL DIRECTOR <u>Henry Washington</u>			24a. REC'D BY REGISTRAR <u>May 24 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

V.S. A15ME  
SM 9/60

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-5741-101  
HEALTH DEPT.

74

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: \_\_\_\_\_

3. AGE: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_

5. PLACE OF BIRTH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. MARITAL STATUS: \_\_\_\_\_

8. EDUCATION: \_\_\_\_\_

9. RELIGION: \_\_\_\_\_

10. RACE: \_\_\_\_\_

11. COLOR: \_\_\_\_\_

12. ETHNIC ORIGIN: \_\_\_\_\_

13. SOCIAL SECURITY NUMBER: \_\_\_\_\_

14. HOME ADDRESS: \_\_\_\_\_

15. PHONE NUMBER: \_\_\_\_\_

16. PLACE OF DEATH: \_\_\_\_\_

17. DATE OF DEATH: \_\_\_\_\_

18. TIME OF DEATH: \_\_\_\_\_

19. CAUSE OF DEATH: \_\_\_\_\_

20. MANNER OF DEATH: \_\_\_\_\_

21. SIGNATURE OF MEDICAL EXAMINER: \_\_\_\_\_

22. SIGNATURE OF WITNESS: \_\_\_\_\_

23. SIGNATURE OF CORONER: \_\_\_\_\_

24. SIGNATURE OF JURY: \_\_\_\_\_

25. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

26. SIGNATURE OF SHERIFF: \_\_\_\_\_

27. SIGNATURE OF CLERK: \_\_\_\_\_

28. SIGNATURE OF JUDGE: \_\_\_\_\_

29. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

30. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

31. SIGNATURE OF JURY: \_\_\_\_\_

32. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

33. SIGNATURE OF SHERIFF: \_\_\_\_\_

34. SIGNATURE OF CLERK: \_\_\_\_\_

35. SIGNATURE OF JUDGE: \_\_\_\_\_

36. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

37. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

38. SIGNATURE OF JURY: \_\_\_\_\_

39. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

40. SIGNATURE OF SHERIFF: \_\_\_\_\_

41. SIGNATURE OF CLERK: \_\_\_\_\_

42. SIGNATURE OF JUDGE: \_\_\_\_\_

43. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

44. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

45. SIGNATURE OF JURY: \_\_\_\_\_

46. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

47. SIGNATURE OF SHERIFF: \_\_\_\_\_

48. SIGNATURE OF CLERK: \_\_\_\_\_

49. SIGNATURE OF JUDGE: \_\_\_\_\_

50. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

51. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

52. SIGNATURE OF JURY: \_\_\_\_\_

53. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

54. SIGNATURE OF SHERIFF: \_\_\_\_\_

55. SIGNATURE OF CLERK: \_\_\_\_\_

56. SIGNATURE OF JUDGE: \_\_\_\_\_

57. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

58. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

59. SIGNATURE OF JURY: \_\_\_\_\_

60. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

61. SIGNATURE OF SHERIFF: \_\_\_\_\_

62. SIGNATURE OF CLERK: \_\_\_\_\_

63. SIGNATURE OF JUDGE: \_\_\_\_\_

64. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

65. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

66. SIGNATURE OF JURY: \_\_\_\_\_

67. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

68. SIGNATURE OF SHERIFF: \_\_\_\_\_

69. SIGNATURE OF CLERK: \_\_\_\_\_

70. SIGNATURE OF JUDGE: \_\_\_\_\_

71. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

72. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

73. SIGNATURE OF JURY: \_\_\_\_\_

74. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

75. SIGNATURE OF SHERIFF: \_\_\_\_\_

76. SIGNATURE OF CLERK: \_\_\_\_\_

77. SIGNATURE OF JUDGE: \_\_\_\_\_

78. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

79. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

80. SIGNATURE OF JURY: \_\_\_\_\_

81. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

82. SIGNATURE OF SHERIFF: \_\_\_\_\_

83. SIGNATURE OF CLERK: \_\_\_\_\_

84. SIGNATURE OF JUDGE: \_\_\_\_\_

85. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

86. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

87. SIGNATURE OF JURY: \_\_\_\_\_

88. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

89. SIGNATURE OF SHERIFF: \_\_\_\_\_

90. SIGNATURE OF CLERK: \_\_\_\_\_

91. SIGNATURE OF JUDGE: \_\_\_\_\_

92. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

93. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

94. SIGNATURE OF JURY: \_\_\_\_\_

95. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

96. SIGNATURE OF SHERIFF: \_\_\_\_\_

97. SIGNATURE OF CLERK: \_\_\_\_\_

98. SIGNATURE OF JUDGE: \_\_\_\_\_

99. SIGNATURE OF PROSECUTOR: \_\_\_\_\_

100. SIGNATURE OF DEFENSE ATTORNEY: \_\_\_\_\_

TO HEALTH OFFICIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6019

06008

<b>1. PLACE OF DEATH</b> a. COUNTY Prince George		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1214 58th Ave.	
<b>3. NAME OF DECEASED</b> (Type or print) Peter		First Middle Last Vanders		<b>4. DATE OF DEATH</b> Month May Day 5 Year 1961	
<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> white	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 1-26-1886		<b>9. AGE</b> (In years last birthday) 75 yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Retired Merchant		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Latvia	
<b>13. FATHER'S NAME</b> Augusta Vanders		<b>12. CITIZEN OF WHAT COUNTRY?</b> Latvia			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) no		<b>16. SOCIAL SECURITY NO.</b> no		<b>17. INFORMANT</b> Mrs. Karlis Bilzens-	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Prostate</i> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebro Vascular Accident</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address 1214 58th Avenue Hillside, Maryland INTERVAL BETWEEN ONSET AND DEATH 2 months 10 days			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> 19		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from April 5, 1961 to May 5, 1961, that (I) (we) last saw the deceased alive on May 5, 1961, and that death occurred 11:30 p.m. the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> William Brainin		<b>22b. DATE SIGNED</b> 5/6/61		<b>22c. PHYSICIAN'S NAME</b> (Type) Dr. Peter D. William Brainin	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 5/9/1961		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Rock Creek Cemetery	
<b>23d. LOCATION</b> (City, town or county) Washington, D.C.		<b>23e. (State)</b>		<b>23f. (Country)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> J. S. H. Hines Co.		<b>24a. ADDRESS</b> 2901-14th St N.W.		<b>24b. REC'D BY REGISTRAR</b> DATE MAY 8 '61	
<b>24c. REGISTRAR'S SIGNATURE</b> Arthur S. Hines		<b>24d. REGISTRAR'S SIGNATURE</b>			



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CONCLUSION

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6021

07149

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN 1b <b>Laurel</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eugene Leland Memorial</b>				d. STREET ADDRESS <b>R #1 Box 128</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>WALLEN</b> Middle <b>WALLEN</b> Last				4. DATE OF DEATH <b>May 31 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-13-95</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>31</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>1</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>general flower grower greenhouse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Greenhouse</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Richard Wallen</b>				14. MOTHER'S MAIDEN NAME <b>Lucille Parrish</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)			
17. INFORMANT <b>Daughter - Nancy Bishop</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>420.0</b> DUE TO <b>Coronary heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arteriosclerotic heart dis</b> (b) <b>10 days</b> (c) <b>3 weeks</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute rheumatoid arthritis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 3, 1961</b> to <b>May 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 31, 1961</b> , and that death occurred at <b>10 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L W Malin</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 31, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. W. Malin M.D.</b>				22d. ADDRESS <b>4404 Queensbury Rd. Riverdale, Md.</b>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF Removal (Specify) <b>Burial June 2, 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Sanage Cem</b>		23d. LOCATION (City, town or county) (State) <b>Sanage Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Hamilton</b>				25a. REC'D BY REGISTRAR <b>JUN 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 22, Film G286 5/12/61 jwk											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi					
c. LENGTH OF STAY IN lb 4 year						d. STREET ADDRESS 2008 Erie Street					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2008 Erie Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frederick Gray Weeks						4. DATE OF DEATH May 7 1961					
5. SEX male						6. COLOR OR RACE white					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH April 1, 1916					
9. AGE (In years last birthday) 45 yrs.						10. IF UNDER 1 YEAR Months Days					
11. IF UNDER 24 HRS. Hours Min.						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) art manager						10b. KIND OF BUSINESS OR INDUSTRY G.C. Murphy Co Pennsylvania					
13. FATHER'S NAME Frederick J. Weeks						14. MOTHER'S MAIDEN NAME Elsie L. Gray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWII						16. SOCIAL SECURITY NO. 196-03-7984					
17. INFORMANT Mrs Evelyn Weeks, same as #2						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO						INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Coronary occlusion											
(c) Coronary artery disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19						20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED May 7, 1961					
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF May 11, 1961					
22c. NAME OF CEMETERY OR CREMATORY Hellerstown Cem.						22d. LOCATION (City, town, or country) (State) Bethlehem, Penna.					
23. FUNERAL DIRECTOR JW Less						24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					
ADDRESS 300-4th St. N.E. Wash. D.C.						DATE MAY 10 '61					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 7, 8, 11 & 14 Film G287 5/22/61 mh											
06011											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>PR. GEO.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>						c. LENGTH OF STAY IN 1b <b>4 1/2 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SOUTHERN MARYLAND Hosp. CENTER</b>						d. STREET ADDRESS <b>RT 2 Box 190 W</b>					
3. NAME OF DECEASED (Type or print) <b>CECELIA</b>						4. DATE OF DEATH <b>MAY 15 1961</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/4/1887</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>					
11. CITIZEN OF WHAT COUNTRY <b>USA</b>						12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13. FATHER'S NAME <b>John Proctor</b>						14. MOTHER'S MAIDEN NAME <b>Ellen Holliday</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>						16. SOCIAL SECURITY NO. <b>—</b>					
17. INFORMANT <b>JOSEPH WILKES - SON -</b>						Address <b>RT 2 Box 190 CLINTON, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CEREBRAL THROMBOSIS</b> (c) <b>ARTERIOSCLEROTIC-CARDIOVASCULAR DISEASE 2+ YEARS</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN. 9 DAYS</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>											
20c. TIME OF INJURY Month, Day, Year <b>NONE</b>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>			
20f. (City or town) <b>NONE</b>				20g. (County) <b>NONE</b>				20h. (State) <b>NONE</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 8, 1961</b> to <b>PRESENT</b> . That (I) (we) last saw the deceased alive on <b>MAY 14, 1961</b> , and that death occurred <b>2 1/2 hrs</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Arthur Shaver Jr.</b> M.D.						22b. DATE SIGNED <b>MAY 18 '61</b>					
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. MD.</b>						22d. ADDRESS <b>BRANCH AVE. CLINTON, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>5/18/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L CEM. ARLINGTON, VIRGINIA</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Smith</b>				24a. ADDRESS <b>1820-9 1/2 St. W. WASHINGTON, D.C.</b>				25a. REC'D BY REGISTRAR <b>MAY 18 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Shaver</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Shaver</b>				25d. REGISTRAR'S SIGNATURE <b>Arthur S. Shaver</b>			

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Items 7, 8, 11 & 14 Film G287 5/22/61 mh

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6024

Item 7 Film G288

5/26/61

06012

1. PLACE OF DEATH  
a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

25 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

College Park

d. STREET ADDRESS

9066 Baltimore Bulvd.

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)

Clarence

Leroy

Wood

DATE OF DEATH

May 20

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

5-7-86

9. AGE (In years last birthday)

75 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Insurance

11. BIRTHPLACE (County & State, or foreign country)

California

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Edward P Wood

Hyattsville Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Shock

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b) Uremia

DUE TO

(c) Adenocarcinoma of the Prostate Gland.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour a.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4/25/61 to 5/20/61, 1961, that (I) (we) last saw the deceased alive on 5/20/61, 1961, and that death occurred at 3:25 P from the causes and on the date stated above.

22a. SIGNATURE

W.L. Etienne

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

W.L. ETIENNE

22d. ADDRESS

College Park, Md 5/22/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

May 24, 1961

23c. NAME OF CEMETERY OR CREMATOR

Arlington National

23d. LOCATION (City, town or county)

Arlington Virginia

24 FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons

ADDRESS

Hyattsville Md

25a. REC'D BY REGISTRAR

MAY 24 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
6025														
06013														
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Clinton									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural					d. STREET ADDRESS 11 Wangerfield Place									
3. NAME OF DECEASED (Type or print) John Warren Wood					DATE OF DEATH May 23 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1876		9. AGE (In years last birthday) 84 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13. FATHER'S NAME Thomas A. Wood					14. MOTHER'S MAIDEN NAME Maria V. Burger									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none					17. INFORMANT Address Thomas E. Wood, same as above				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE James E. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) James I. Boyd					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					Address (Street, city, town, or county) May 23, 1961									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 26-61		22c. NAME OF CEMETERY OR CREMATORY Bulls Cemetery		22d. LOCATION (City, town, or country) (State) Camp Springs Md								
23. FUNERAL DIRECTOR Annors Bros					24a. REC'D BY REGISTRAR 1461-4d Hoped 88					24b. REGISTRAR'S SIGNATURE DATE MAY 25 '61				

Arthur S. Hanks



10011

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6026

## CERTIFICATE OF DEATH

Reg. Dist. No. 06014

1. PLACE OF DEATH a. COUNTY <b>Pr. George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aquasco</b>		c. LENGTH OF STAY IN 1b <b>43 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Hohing</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> , Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1885</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Otto Hohing</b>		14. MOTHER'S MAIDEN NAME <b>Anna Elizabeth Hartig</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Raymond E. Young</b>		Address <b>Aquasco, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Failure</b> <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Coronary Disease</b> DUE TO (c) <b>Chronic Valvular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b> <b>— Year</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>8:00</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 16</b> , 19 <b>54</b> , to <b>May 22</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>May 21</b> , 19 <b>61</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Vahed M. Seron</b> M.D.		ADDRESS (Street, city or town, state) <b>Aquasco, Md.</b> DATE SIGNED <b>5/22/61</b>	
PHYSICIAN'S NAME (Type) <b>V A H E H M. S E R O N M D</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/24/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aquasco Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home—Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 1 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles E. King</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

105K

<p>1. NAME OF DECEASED                  Mrs. Mary Ann Jones</p>		<p>2. SEX                  Female</p>		<p>3. AGE                  75</p>	
<p>4. PLACE OF BIRTH                  Baltimore, Md.</p>		<p>5. DATE OF BIRTH                  Jan. 15, 1880</p>		<p>6. PLACE OF DEATH                  Baltimore, Md.</p>	
<p>7. OCCUPATION                  None</p>		<p>8. CAUSE OF DEATH                  Heart Failure</p>		<p>9. MANNER OF DEATH                  Natural</p>	
<p>10. DATE OF DEATH                  Jan. 15, 1955</p>		<p>11. TIME OF DEATH                  10:30 AM</p>		<p>12. PLACE OF INTERMENT                  St. Mary's Cemetery</p>	
<p>13. SIGNATURE OF DECEASED                  (None)</p>		<p>14. SIGNATURE OF WITNESSES                  (None)</p>		<p>15. SIGNATURE OF PHYSICIAN                  Dr. J. H. Smith</p>	
<p>16. SIGNATURE OF CORONER                  (None)</p>		<p>17. SIGNATURE OF REGISTRAR                  (None)</p>		<p>18. SIGNATURE OF CLERK                  (None)</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6027

06015

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 1 mo., 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1669 Columbia Rd., N.W.	
3. NAME OF DECEASED (Type or print) Guy Yowell		4. DATE OF DEATH May 10 1961	
5. SEX Male	6. COLOR OR RACE White	7. <del>XXXXXXXXXX</del> WIDOWED <input checked="" type="checkbox"/> <del>XXXXXXXXXX</del>	8. DATE OF BIRTH 4/19/92
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days 10 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Madison Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert H. Yowell		14. MOTHER'S MAIDEN NAME Ella Weakley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes ?	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis and shock due to perforated duodenal ulcer DUE TO (b) Duodenal ulcers Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic obstructive emphysema, duration unknown		INTERVAL BETWEEN ONSET AND DEATH 1 day unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 61 Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 28 1961 to May 10 1961, that (I) (we) last saw the deceased alive on May 10 1961, and that death occurred at 6:27 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 5/10/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, OR REMOVAL <del>XXXXXX</del>		23b. DATE THEREOF 5/13/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE S.H. HINES CO.		25a. REC'D BY REGISTRAR DATE MAY 15 '61	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

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STATE OF TEXAS,  
COUNTY OF \_\_\_\_\_

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